



Today's Date:

## REGISTRATION FORM

### Patient

Name (Last, First, M.I.):		Maiden name:	
		DOB:	<input type="checkbox"/> M <input type="checkbox"/> F
Street Address	City	St	Zip
Preferred Contact Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell			
Home Phone	Work Phone	Cell Phone	
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Emergency Contact and Phone:	

### Employer

Employer Name

Employer Address

### Primary Insurance

Insurance Company Name:	Co-pay:	
Subscriber's ID:	Group Number:	
Subscriber's Name:	Subscriber's employer:	
Subscriber's DOB:	Subscriber's sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Subscriber:

### Secondary Insurance

Insurance Company Name:	Co-pay:	
Subscriber's ID:	Group Number:	
Subscriber's Name:	Subscriber's employer:	
Subscriber's DOB:	Subscriber's sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Subscriber:

### Responsible Party (who is in responsible for any balances on this account?)

Self  Parent  Guardian  L & I  Worker's Comp.  Employer Contract

Name (Last, First, M.I.):			
Street Address	City	St	Zip
Home Phone	Work Phone	Cell Phone	
Worker's Compensation/ L&I Claim Number:	Date of Injury:		
Employer Name:			

### Referred By (how were you referred to the Institute of Complementary Medicine?)

Insurance directory  Website  Yellow pages  Friend  Relative  Physician

Whom may we thank?  Name

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic.

Signature:	Date:
<input type="text"/>	<input type="text"/>