ONE SKY FAMILY MEDICINE

6300 9th Ave NE, Suite #300, Seattle, WA 98115 Phone (206) 363-5555 Fax (206) 363-5533

PATIENT REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP_____

PATIENT INFORMATION

Patient's Last Name First Middle	Marital Status (Circle One) Single / Married / Divorced / Partnered / Domestic Partnered/ Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex:

Street Address	ZIP Code	Social Security	Home Ph. ( ) ok to leave message?

City State	Email address:	Cell Ph. ( ) ok to leave message?

Occupation	Employer	Work Ph. ( ) ok to leave message?

We would love to know how you found us! ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Our website ❑ Another Website ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Regence ❑ Premera ❑ First Choice ❑ Aetna ❑ Group Health ❑ Cigna ❑ Medicaid ❑ Medicare ❑ United ❑ Other _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative we can contact in case of emergency	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **One Sky Family Medicine** or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE