Snoqualmie Valley Clinic – Registration Form

PATIENT INFORMATION					
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Race White Black Hispanic Asian Pacific Islander Other	Birth date: / /	Age:	Sex: ❑ M ❑ F
Social Security no.:	Home phone no.: ( )	Cell Phone no.: ( )			
Street address:	City:	State:	ZIP Code:		
Mailing address:	City:	State:	Zip Code:		
Email address:	Preferred pharmacy name & Location				
Occupation:	Employer:	Employer phone no.: ( )			
Referred to clinic by:					
Other family members seen here:					

If patient is a minor, name of 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.: ( )

INSURANCE INFORMATION					
Is this patient covered by insurance? ❑ Yes ❑ No	Name of insurance plan:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-pay: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

CONSENT FOR CARE AND AGREEMENT TO PAY: I hereby consent to all medical or surgical treatment prescribed by the attending physician, or provider, and performance of all examinations, treatments, medications and procedures deemed necessary. I authorize the provider or their authorized staff, or the insurance company to release any information required for the processing of claims. I understand that I am financially responsible for any balance, regardless of insurance coverage.
ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to Snoqualmie Valley Clinic any insurance benefits payable for myself and/or covered member.

I have read the above and understand it's content.

Patient/Guardian signature *Date*