Seattle Sports & Regenerative Medicine

PATIENT REGISTRATION

Patient Name _____ ☐ Male ☐ Female
last first middle initial nickname

Mailing Address _____ Home Phone _____
street apt. #

_____ Day/Cell Phone _____ e-mail _____
city state zip

The federal government requires that we collect the following information:

Marital Status

☐ Single ☐ Married
☐ Separated ☐ Widow/er
☐ Dependent ☐ Domestic Partner

Race

☐ White/Caucasian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Prefer Not to Disclose
☐ Other _____ ☐ Unknown

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer Not to Disclose
☐ Unknown

Preferred Language _____

Birthdate ____/____/____ Age _____ Social Security# _____

Primary Care Physician _____
last first

Referred by Dr. _____ Phone _____
last first

Patient's Employer/School _____ Phone _____

Emergency Contact Information:

Name _____ Phone _____

PRIMARY INSURANCE

Ins. Co. Name _____

Subscriber Name _____

Birthdate ____/____/____

Group # _____ ID # _____

Subscriber's Employer _____

Does your insurance carrier require a referral? ☐ Yes ☐ No

SECONDARY INSURANCE

Ins. Co. Name _____

Subscriber Name _____

Birthdate ____/____/____

Group # _____ ID # _____

Subscriber's Employer _____

BILLING INFORMATION

(Complete if person responsible for bill is not the patient.)

Name of Person Responsible for Bill _____
relationship social security #

Address (if not as above) _____
street city state zip

Home Phone _____ Employer _____

Work Phone _____ Address _____

PREFERRED PHARMACY

Preferred Pharmacy Name: _____ Location/# _____

2nd Preferred Pharmacy Name: _____ Location/# _____

HOW WERE YOU RECOMMENDED TO US?

Hospital/Emergency Room _____ Internet _____ Postcard / Mailing _____ TV / Radio _____

Friend / Family _____ Referring Doctor _____ Other _____

Seminar/Event _____ Magazine/Newspaper _____

I have read and acknowledged the Seattle Sports & Regenerative Medicine patient financial policy and authorize my insurance benefits to be paid to Seattle Sports & Regenerative Medicine. I consent to the release of any information, by insurance or provider, required to get my claim paid. Furthermore, I understand I am financially responsible for any balance that my insurance does not pay.

_____ _____
signature date