SEATTLE NATURE CURE CLINIC, P.S.

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PATIENT REGISTRATION

Patient Name: Mi: Last:
Street Address: Email:
City: State: Zip:
SSN: Gender: ( )M ( )F ( ) Other Home ph: ( )
Employer: Work ph: ( )
Date of Birth: / / Age: Alt. ph ( )
Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other
Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependant ( )Partnered ( )Other
Responsible Party: Phone: ( )
Address: City, ST, ZIP:
Emergency contact: Phone: ( )
Referred By:

PRIMARY INSURANCE

Insurance Company Name: Phone: ( )
Claims Address: City, ST, ZIP:
Subscribers Name: Date of Birth: / / SSN:
Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other
Subscribers Address: City, ST, ZIP:
I.D. # **as shown on card**: Group #:
Employer of Insured: Phone: ( )

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? ( )Yes ( )No Work related? ( )Yes ( )No Auto accident? ( )Yes ( )No
Insurance Company Name: Phone: ( )
Claims Address: City, ST, ZIP:
Subscribers Name: Date of Birth: / / SSN:
Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other
Subscribers Address: City, ST, ZIP:
I.D. # **as shown on card**: Group #:
Employer of Insured: Phone: ( )

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: **Date:**