

Western Washington Medical Group
Department of Ear, Nose, Throat and Audiology

_____ NEW _____ UPDATE

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME (legal): _____ MI _____ PREFERRED OR NICKNAME: _____
DATE OF BIRTH: _____ SEX: MALE FEMALE MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED CHILD
ADDRESS: _____ APT: _____ CITY: _____ STATE: _____ ZIP: _____
MAILING ADDRESS: _____
HOME PHONE: (____) _____ WORK PHONE: (____) _____ CELL PHONE: (____) _____
PHONE NUMBER FOR CONFIDENTIAL MESSAGES: (____) _____ INITIALS: _____
 DO **NOT** LEAVE MESSAGES REGARDING MY CASE. INITIALS: _____
SOCIAL SECURITY NUMBER: _____ PHARMACY: _____ PHARMACY PHONE: (____) _____
DOCTOR WHO REFERRED YOU: _____ PRIMARY CARE DOCTOR: _____

PRIMARY INSURANCE:

INSURANCE COMPANY: _____ COPAY: _____
SUBSCRIBER (CARD HOLDER): _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT/GUARDIAN OTHER _____
EMPLOYER: _____ ID #: _____ GROUP #: _____

SECONDARY INSURANCE:

INSURANCE COMPANY: _____ COPAY: _____
SUBSCRIBER (CARD HOLDER): _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT/GUARDIAN OTHER _____
EMPLOYER: _____ ID #: _____ GROUP #: _____

RESPONSIBLE PARTY:

NAME: _____ SELF PARENT GUARDIAN OTHER _____
DATE OF BIRTH: _____ SEX: MALE FEMALE HOME PHONE: (____) _____ WORK PHONE (____) _____
EMERGENCY CONTACT: _____ PHONE (____) _____ RELATIONSHIP: _____

I, THE PATIENT OR RESPONSIBLE PARTY, 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 AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. I AUTHORIZE THE PHYSICIAN AND CLINIC TO RELEASE MY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE TO PAY CLAIMS DIRECTLY TO THE PHYSICIAN OR CLINIC.

SIGNATURE: _____ DATE: _____

I ACKNOWLEDGE RECEIPT OF THE MEDICAL RECORD PRIVACY POLICY

SIGNATURE: _____ DATE: _____