REGISTRATION

Please Print

Date ______________________ Is this your first visit to a PacMed Clinic? Y ________ N ________

PATIENT INFORMATION

Name ______________________ SSN ______________________

AKA (Nickname) ______________________ Birth Name ______________________

Date of Birth (MM/DD/YY) ______________________ Sex M F Married or Single

Permanent Address:
Street ______________________ City ______________________ State/Zip Code ______________________

Mailing Address:
Street ______________________ City ______________________ State/Zip Code ______________________

Home Phone ( ) ______________________ Cell Phone ( ) ______________________

Message/Alternate Phone ( ) ______________________

Occupation ______________________ Employer ______________________

Work Phone ( ) ______________________

Who is your primary medical care provider (PCP)? Name ______________________

Address/Clinic ______________________ Phone ( ) ______________________

Please send me an electronic version of the PacMed patient newsletter. Email address: ______________________
****We value your privacy and will not share your email address with anyone.*

RESPONSIBLE PARTY INFORMATION

Responsible Party Name ______________________ SSN ______________________

Relationship to Patient ______________________ DOB: ______________________

Permanent Address:
Street ______________________ City ______________________ State/Zip Code ______________________

Occupation ______________________ Employer ______________________

Business Address ______________________

Home Phone ( ) ______________________ Work Phone ( ) ______________________

1200 - 12th Ave. S., Seattle, WA 98144 www.pacmed.org

B00055 (Rev. 07/2009)

Patient Name:

DOB:

MRN:

Clinic Location:

PATIENT EMERGENCY CONTACT

Contact Name ______________________________ Relationship ______________________________

Home Phone ( ) ______________________________ Work Phone ( ) ______________________________

Message/Alternate Phone/Cell ( )______________________________

INSURANCE INFORMATION

Is your condition related to employment (current or previous employer)? Y N

Is your condition related to other accident? Y N

Are you covered under any of these programs?

Medicare Y N Medicaid Y N CHAMPUS Y N CHAMPVA Y N USFHP Y N Worker's Compensation Y N

If yes, Claim Number: ______________________________

Do you have medical Insurance? Y N

If yes:

Name of Primary Insurance Carrier______________________________

Contract # ______________________________ Group # ______________________________Subscriber # ______________________________

Subscriber Name______________________________ Employer ______________________________

Name of Secondary Insurance Carrier ______________________________

Contract # ______________________________ Group # ______________________________Subscriber # ______________________________

Subscriber Name______________________________ Employer ______________________________

PLEASE NOTE, PACMED CLINICS DO NOT ACCEPT LIENS OR BILL FOR 3RD PARTY MOTOR VECHICLE OR OTHER ACCIDENTS.

I CERTIFY THAT THE INFORMATION I HAVE GIVEN ABOVE IS TRUE AND CORRECT:

Patient/Parent or other authorized representative signature______________________________

Date______________________________