



PATIENT PRE-REGISTRATION FORM **First Hill** **Cherry Hill** **Ballard** **Issaquah**

Please select type of service: **Diagnostic** **OB** **Surgery** **Clinic**

Primary Care Physician: _____ Phone: _____

Patient Name: _____ Social Security #: _____

Sex: _____ Date of Birth: _____

Marital Status: _____ Religious Preference: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

If retired, date of retirement: _____ Employer: _____

Primary Insurance

Insurance: _____ Plan type (HMO/PPO): _____

Policy #: _____ Group #: _____

Ins. Co. Billing Address: _____

Phone: _____

Policy Holder: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

If policy holder of insurance (in order to bill properly): Social Security #: _____ Date of Birth: _____

If retired, date of retirement: _____ Employer: _____

Contacts

Primary contact: _____ Relationship to patient: _____

Home Phone: _____ Emergency: _____

Secondary contact: _____ Relationship to patient: _____

Home Phone: _____ Emergency: _____

CONTACT YOUR PCP OR INSURANCE COMPANY IF YOU ARE UNSURE ABOUT REFERRAL/AUTHORIZATION REQUIREMENTS

Medicaid/Healthy Options

If eligible for Department of Social & Health Services:

Plan: _____

Plan/Member# _____ Case No: _____

PIC #: _____ *Pic # example: JA 070476 SMITH A*

Secondary Insurance

Insurance: _____ Plan type (HMO/PPO): _____

Policy #: _____ Group #: _____

Ins. Co. Billing Address: _____

Phone: _____

Policy Holder: _____

