

**NORTHWEST WOMEN'S
HEALTH CARE**

1101 Madison – Suite 1150
Seattle, Washington 98104

PATIENT REGISTRATION
PLEASE PRINT IN BLACK OR BLUE INK

PATIENT NAME _____ FEMALE _____ MALE _____
LAST FIRST MIDDLE INITIAL

MAILING ADDRESS _____ HOME PHONE # _____
STREET APT. NO.

_____ CELL PHONE # _____
CITY STATE ZIP

EMAIL ADDRESS _____

MARRIED _____ SEPARATED _____ SINGLE _____ WIDOW/ER _____ DIVORCED _____ PARTNER _____

BIRTHDATE ____/____/____ AGE _____ SOCIAL SECURITY NO. _____ OCCUPATION _____

PATIENT'S EMPLOYER _____ WORK PHONE # _____

NAME (SPOUSE/PARENT/PARTNER) _____

EMPLOYER _____ OCCUPATION _____

DOB _____ /SS # _____ WORK PHONE # _____

BILLING INFORMATION

NAME OF PERSON RESPONSIBLE FOR BILL _____
(SELF/RELATIONSHIP) SOCIAL SECURITY NUMBER

BIRTHDATE ____/____/____

PLACE INSURANCE CARD HERE

_____ PATIENT IS A SELF PAY

DRUG ALLERGIES _____

REFERRED BY _____

EMERGENCY CONTACT
(SOMEONE NOT LIVING WITH YOU) _____ RELATIONSHIP _____

ADDRESS _____ PHONE # _____

ASSIGNMENTS OF BENEFITS

I authorize payment of medical benefits to the physicians of Northwest Women's Health Care. I also authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account.

The above information is complete and accurate to the best of my knowledge.

PATIENT OR GUARDIAN'S SIGNATURE

DATE