Patient Information

Patient Name: ____
LAST FIRST M.I. NICKNAME

Birth Date: _____ / _____ / __________ Primary Language: ____________________

Sex: ______________________________ Gender Identity: ____________________

Prefered Pronouns: ____________________ Social Security Number: _____ - _____ - _____

Patient Address: ____
STREET CITY, STATE ZIP CODE

Primary Phone: ____________________
☐ HOME ☐ CELL ☐ WORK

Secondary Phone: ____________________
☐ HOME ☐ CELL ☐ WORK

Email Address: ____________________ Employer: ____________________

Emergency Contact: ____
NAME PHONE RELATIONSHIP

Referred By: ____

In order to bill your insurance(s) we must have a copy of your insurance card(s) presented at each visit.

INSURANCE INFORMATION

Primary Insurance Provider: ____

Is the patient the subscriber? ☐ YES ☐ NO

Secondary Insurance Provider: ____

Is the patient the subscriber? ☐ YES ☐ NO

If double covered, have you notified each Insurance of the other health plan? ☐ YES ☐ NO

INSURANCE DISCLAIMER AND ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Seattle OBGYN Group & Northwest Women's Healthcare and authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for all account balances. I acknowledge that all insurance information has been provided including primary and secondary insurance. Any insurance non-payment due to coordination of benefits will be my responsibility and subject to administrative fees as applies.

Signature: ______________________________ Date: ______________

FOR FUTURE USE:

Initials: __________ Date: __________ Initials: __________ Date: __________

Initials: __________ Date: __________ Initials: __________ Date: __________