## PATIENT INFORMATION

SEATTLE OB/GYN GROUP
1101 Madison Street, Suite 950
Seattle, WA 98104

NORTHWEST WOMEN'S HEALTHCARE
1101 Madison Street, Suite 1150
Seattle, WA 98104

Patient Name: _____
LAST FIRST M.I. NICKNAME

Date of Birth: ____ / ____ / ____ Sex: _____ Gender Identity: _____ Primary Language: _____

Marital Status: _____ Social Security Number: _____ - _____ - _____

Patient Address: _____
STREET CITY, STATE ZIP CODE

Primary Phone: _____
CIRCLE ONE: HOME CELL WORK

Secondary Phone: _____
CIRCLE ONE: 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 Company:** _____

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: _____

PROLIANCE SURGEONS