



Today's Date: ____/____/____

REGISTRATION

(Please Print)

PATIENT INFORMATION

Last Name		First		Middle	
Marital Status (circle one) Single / Mar / Div / Sep / Wid	Birthdate / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.	Home Phone No. ()
Street Address (P.O. Box if necessary)					
City		State		Zip Code	
Email Address					
Employer		Occupation		Employer Phone No. ()	
Chose clinic because / Referred to clinic by: (please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital					
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other:					

INSURANCE INFORMATION

Person Responsible for Bill		Address (if different)		Home Phone No. ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Employer		Employer Address		Employer Phone No. ()	
Is the patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate Primary Insurance: <input type="checkbox"/> Regence <input type="checkbox"/> Blue Cross <input type="checkbox"/> Great West <input type="checkbox"/> Sound Health <input type="checkbox"/> First Choice <input type="checkbox"/> Health Plus					
<input type="checkbox"/> PacifiCare of WA <input type="checkbox"/> Medicare <input type="checkbox"/> Welfare (DSHS) <input type="checkbox"/> Other _____ (Please provide coupon)					

Subscriber's Name	Subscriber's S.S. No.	Birthdate / /	Group #	Policy #	Co-Payment \$
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance (if applicable)		Subscriber's Name	Group #	Policy #	

IN CASE OF EMERGENCY

Name of local Friend or Relative	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Terry L. Jacobson, MD or the insurance company to release any information required to process my claims.

X _____
Patient/Guardian Signature

____/____/____
Date