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EASTSIDE INTEGRATIVE HEALTH, PLLC

1239 120TH AVENUE NE, SUITE E
BELLEVUE, WA 98005
PHONE (425) 457-7799 · FAX (425) 614-0678

PATIENT REGISTRATION

Please fill out completely

Patient Name: MI: Last:

Street Address: E-mail:

City: State: Zip:

SSN: Gender: ☐M ☐F Home ph:

Employer: Work ph:

Date of Birth: Age: Alt ph:

Employment: ☐Employed ☐F/T Student ☐P/T Student ☐Retired ☐Other

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Dependant ☐Partnered ☐Other

Responsible Party: Phone:

Address: City, ST, ZIP:

In emergency contact: Phone:

Referred By:

PRIMARY INSURANCE

Insurance Company Name: Phone:

Claims Address: City, ST, ZIP:

Subscriber's Name: Date of Birth: SSN:

Relationship to you: ☐Self ☐Spouse ☐Dependant ☐Other

Subscribers Address: City, ST, ZIP:

I.D. # **as shown on card**: Group #:

Employer of insured: Phone:

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? ☐Y ☐N Work related? ☐Y ☐N Auto accident? ☐Y ☐N State:_____

Insurance Company Name: Phone:

Claims Address: City, ST, ZIP:

Subscriber's Name: Date of Birth: SSN:

Relationship to you: ☐Self ☐Spouse ☐Dependant ☐Other

Subscribers Address: City, ST, ZIP:

I.D. # **as shown on card**: Group #:

Employer of insured: Phone:

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assesed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature Date