NW pain relief centers

(Please Print Clearly)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Last name:	First:	MI:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Primary phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer City:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Walk-In

❑ Family ❑ Friend ❑ Close by home/work ❑ Newspaper ad ❑ Other: _____

Who were you referred by?

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Please indicate primary insurance ❑ Premera ❑ Regence ❑ Aetna ❑ First Choice ❑ Cigna

❑ Medicare ❑ Lifewise ❑ Medicaid ❑ Group Health Options ❑ Other: _____

ID no.:	Group no.:

Claims address (found on back of card):	Phone no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of secondary insurance (if applicable):	Subscriber's name:	ID no.:	Group no.:

Claims address (found on back of card):	Phone no:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

X

Patient/Guardian signature *Date*