



# The Seattle Arthritis Clinic

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SEATTLE, WA 98133

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[www.theseattlearthritisclinic.org](http://www.theseattlearthritisclinic.org)

## PATIENT REGISTRATION PLEASE PRINT AND ANSWER ALL QUESTIONS

### PATIENT INFORMATION

Ms.  Mr.  Dr.

Marital Status  S  M  D  W

Patient \_\_\_\_\_  Female  Male  
(Full Legal Name) Last Middle First

Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Referred to this office by \_\_\_\_\_ Your Email: \_\_\_\_\_

Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Work Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Relative or Friend \_\_\_\_\_ Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_

### BILLING

Person Responsible for Bill \_\_\_\_\_

Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

### HEALTH INSURANCE

Patient is  Subscriber  Spouse  Dependent

Subscriber Name \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Is this visit the result of a work-related injury?  Yes  No

Labor & Industries Claim No. \_\_\_\_\_ Claims Mgr. \_\_\_\_\_ Phone \_\_\_\_\_

Employer at time of injury \_\_\_\_\_ Date of injury \_\_\_\_\_

### RELEASE

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits be paid directly to Northwest Counseling Associates. I understand that it is my responsibility to know and understand my insurance policy and its benefits. I understand that some services may not be covered by my insurance under the terms of my policy. I

understand that I am responsible for all bills incurred at this office and I agree to make financial arrangements with my provider to pay for any services not covered by my insurance policy. I am financially responsible for any balance due, including the 1.5% per month service charge (\$2.00 minimum) on balances over 90 days.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_