UW Medicine

NORTHWEST HOSPITAL & MEDICAL CENTER

AMBULATORY NETWORK

Patient Registration Information

LEGAL NAME (Please print)							
Last Name	First Name			Middle Name			
Social Security Number	Sex	Date of Birth	Name you preferred to be called/Alias				
Street Address		City		State	Zip		
Home Phone	Work Phone	Cell Phone	Email				
Marital Status	Previous/Maiden Name	Written Language	Spoken Language				
Interpreter Needed?	VA Status ☐ Yes ☐ No	Race/Ethnicity (optional)					
Primary Care Provider (Name and Phone)	Employer Name						

Emergency Contact/Legal Next of Kin

Emergency Contact	Relation	Home Phone	Work Phone	Cell Phone
Legal Next of Kin *(if different than above)* – Name	Relation	Home Phone	Work Phone	Cell Phone

Responsible Party Information

Last Name			First Name	MI	Alias or Maiden Name
Date of Birth	Sex	Marital Status	Social Security Number	Relationship to the Patient	
Street Address (if different from above)		City	State	Zip	
Home Phone	Work Phone	Cell Phone			
Employer Name	Occupation	Status			

Insurance Information

PRIMARY INSURANCE					
Insurance Company Name	Group Number	Subscriber ID Number	Copay		
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient		
Subscriber's Employer Name	Subscriber's Home Phone	Subscriber's Work Phone			
SECONDARY INSURANCE					
Insurance Company Name	Group Number	Subscriber ID Number	Copay		
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient		
Subscriber's Employer Name	Subscriber's Home Phone	Subscriber's Work Phone			

Is This Visit Related to Work Injury or Motor Vehicle Accident?

If "yes", please complete the below.

☐ **Work Related Injury?**

Worker's Comp (Includes Labor & Industries)

Employer:		Date of Injury:
Body Part Injured and Description:		Claim Number:
Adjuster/Claims Manager Name:		Phone Number:
Insurance Name:	Address:	
City:	State/Zip:	L & I Claim Completed? (*Circle*) Yes / No

☐ **Motor Vehicle Accident (PIP) Insurance?**

Personal Injury Protection Insurance (Third Party/Motor Vehicle):

Date of Injury:	Body Part Injured and Description:
Claim number:	Adjuster/Claims Manager Name:
Adjuster Phone Number:	Insurance Name:
Insurance Address:	
City:	State/Zip:

☐ **Attorney Billing?**

Attorney Information (Add'l Types/Special Physician Svcs):

Attorney Name:	Law Firm Name:
Billing Address:	
City:	State / Zip:
Fax:	Date of Injury:
Body Part Injured and Description:	