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: | |