Northwest Rheumatology
Patient Registration Form

Patient Information:

Last Name: __________________ First Name: _______________ Middle: __________ Birth Date: ________
Address:________________________________ City:___________ State:____________ Zip:________________
Home #______________________ Work #___________________ Mobile#___________ Age_______ Sex______
Marital Status:________________ SSN#__________________ Email:_________________________________

Primary Insurance Information

Name:_______________________ Policy #__________________________ Group #______________________
Copay Amount_____________________

Secondary Insurance Information

Name:_______________________ Policy #__________________________ Group #______________________
Copay Amount_____________________

Employer or School Information

Name:_______________________ Phone #__________________________ Status #______________________
Address:____ Occupation:__________________________
City:_________________________ State:___________________________ Zip:________________

Referring Physician Information

Name:_______________________ Phone #__________________________ Fax #______________________
Address:_____________________ City:_____________________ State:_____________ Zip:_____________

Primary Physician Information

Name:_______________________ Phone #__________________________ Fax #______________________
Address:_____________________ City:_____________________ State:_____________ Zip:_____________

FOR MINORS

Mother Information:

Name:__________________________________
Address:________________________________
City/ST/Zip:_____________________________
Phone H/W:______________________________

Father Information:

Name:_______________________________________
Address:_____________________________________
City/ST/Zip:_________________________________
Phone H/W:__________________________________

Pharmacy

Name:_______________________ Phone #__________________________ Fax #______________________
Address:_____________________ City:_____________________ State:_____________ Zip:_____________

Authorization to Pay: I hereby authorize payment directly to the business office of Northwest Rheumatology for sevices rendered. I understand that I am financially responsible for the charges not covered by my insurance. Any expenses incurred including reasonable attorney's fees and cost of default in payment of the doctor fees, shall be paid by me.

Signed____ **Date:**______________________