New Patient Registration Information

PATIENT INFO	PRMATION													
Last Name		First Na	First Name				Middle Name							
Social Security Number Gender				Date of Birth				Name you preferred to be called/Alias						
Street Address					City			State			4	Zip		
Home Phone Work Phone			e	Cell Phone				Er	nail					
Marital Status Previous/Maiden Name				Written Language Sp					Spo	ooken Language				
Interpreter Needed?				VA Status ☐ No				Race/Ethnicity (optional)						
Primary Care Pro	ovider (Name	and Phon	e)		Er	mployer N	lame	⊥ ∋						
, , , , , ,			- /			1 - 7 -								
Emergency Contact Relati		on			Home Phone		Work Phone		Э	Cell P		Phone		
Legal Next of Kin (if different) Rela		Relati	on	1		Home Phone		Work Phone		C	Cell Phone			
RESPONSIBL	E PARTY IN	NFORMA	TION (if	diffe	rent fro	m patie	nt)							
Last Name				t Nan					N	1I A	lias or	Maider	Name	
Social Security Number Gender Dat				Date of Birth				Relationship to the Patient						
Street Address (if different from above)					City			State				Zip		
Home Phone Work Pho			k Phone	ione				Cell Phone						
Employer Name				Occupation			on	n				Status		
PRIMARY INS	URANCE													
Insurance Company Name Group N				ıp Nu	Number				Subscriber ID Number Copay					
Subscriber's Name Social S				ial Security Number				Date of Birth Relationship to Patient					ent	
Subscriber's Employer Name				,	Subscriber's Home Phone Subscri					ber's V	per's Work Phone			
SECONDARY	INSURANC	E								_L				
Insurance Company Name Group N				ıp Nu	umber				Subscriber ID Number Copay					
Subscriber's Name Social S				al Se	ecurity Number				Date of Birth Relationship to Patient				ent	
Subscriber's Employer Name				Ç	Subscriber's Home Phone				Subscriber's Work Phone					

UW Medicine

Harborview Medical Center – University of Washington Medical Center UW Medicine Primary Care – Valley Medical Center – UW Physicians

NEW PATIENT REGISTRATION INFORMATION Page 1 of 2

DO NOT LABEL OR SCAN

DO NOT SCAN OR UPLOAD TO THE MEDICAL RECORD

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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 & Inc	dustries)									
Employer:		Date of Injury:								
Body Part Injured and Description:		Claim Number:								
Adjuster/Claims Manager Name: Pho				one Number:						
Insurance Name:		Address:								
City:	State/	Zip:		L & I Claim Completed? Yes	No					
				1						
☐ Motor Vehicle Accident (PIP) Insu	irance									
Personal Injury Protection Insurance	(Third Par	ty/Motor Vehic	<u>le)</u>							
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:	Zip:									
Fax:		Date	Date of Injury:							
Body Part Injured and Description:										

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