

# VasectomyCenter - Seattle · Eastside · Edmonds

## REGISTRATION FORM

NEW     UPDATE

### PATIENT

SOCIAL SECURITY NUMBER - -		LAST NAME		FIRST NAME		M.I.	
ALIAS OR MAIDEN NAME				EMERGENCY CONTACT; NAME & PHONE NO.			
STREET ADDRESS				CITY		STATE	ZIP
HOME PHONE ( ) -		WORK PHONE ( ) -		WORK EXTENSION		DATE OF BIRTH	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single (S) <input type="checkbox"/> Married (M) <input type="checkbox"/> Divorced (D) <input type="checkbox"/> Widowed (W)		(OPTIONAL) <input type="checkbox"/> Smoker (S) <input type="checkbox"/> Non Smoker (NS) <input type="checkbox"/> Previous Smoker (PS)		RACE (OPTIONAL) <input type="checkbox"/> Caucasian (1) <input type="checkbox"/> Black (2) <input type="checkbox"/> Asian (3) <input type="checkbox"/> Hispanic (4) <input type="checkbox"/> Native American (5)		

We are collecting this information for demographic/research purposes only.

### EMPLOYER

EMPLOYER NAME				
STREET ADDRESS		CITY	STATE	ZIP
OCCUPATION		STUDENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		

### PRIMARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER		COPAY	
SUBSCRIBER'S NAME			SUBSCRIBER'S EMPLOYER		
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SUBSCRIBER'S ID		GROUP NUMBER	

### SECONDARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER		COPAY	
SUBSCRIBER'S NAME			SUBSCRIBER'S EMPLOYER		
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SUBSCRIBER'S ID		GROUP NUMBER	

### RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

Self (1)

<input type="checkbox"/> Parent (3)	SOCIAL SECURITY NUMBER		LAST NAME		FIRST NAME		MI	
	STREET ADDRESS			CITY		STATE	ZIP	
<input type="checkbox"/> Guardian (5)	HOME PHONE ( ) -		WORK PHONE ( ) -		WORK EXT. X	DATE OF BIRTH	SEX M    F	
	<input type="checkbox"/> Workers Compensation (6)			Claim #:		Date of Injury:		
<input type="checkbox"/> Employer Contract (10)			Employer Name					

### REFERRED BY HOW WERE YOU REFERRED

<input type="checkbox"/> Yellow Pages (YP)	<input type="checkbox"/> Consulting Nurse Service (CN)	<input type="checkbox"/> Television Advertisement (TV)
<input type="checkbox"/> Newspaper Advertisement (NEW)	<input type="checkbox"/> Radio Advertisement (RAD)	<input type="checkbox"/> Insurance Company Directory (INS)
<input type="checkbox"/> Friend or Relative Recommendation (REC) _____		<input type="checkbox"/> Physician (DR) _____

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIM FORMS. I ALSO AUTHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC.

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_