PeaceHealth Medical Group

Woolley Wellness Clinic
1235 3rd Street Sedro-Woolley, WA 98284
Phone: (360) 856-7995 Fax: 360-856-8000

PLEASE ANSWER ALL QUESTIONS _____

Patient Full Name: _____

Patient's Social Security Number: _____ SEX: _____ AGE: _____

Mailing Address: _____ APT # _____ BIRTHDATE: ___/___/___

City/State/Zip: _____ Home Phone:_____

PATIENT'S EMPLOYER: _____ OCCUPATION:_____

BUSINESS PHONE: _____ MARITAL STATUS **(circle one):** Single Married Divorced Separated Widowed

SPOUSE: _____ EMPLOYER: _____WORK PHONE: _____

PERSON RESPONSIBLE FOR PAYMENT IS: _____ PATIENT _____ SPOUSE _____ PARENT

NAME:_____ ADDRESS:_____
(if different from above)

PHONE:_____ SOCIAL SECURITY NUMBER: _____ DOB:_____

IN CASE OF EMERGENCY, CONTACT (person NOT residing with you):

NAME:_____ PHONE:_____

RELATIONSHIP TO PATIENT: _____

DO YOU HAVE MEDICAL INSURANCE? YES NO

NAME OF PRIMARY INSURANCE COMPANY _____

SUBSCRIBER'S NAME_____ DATE OF BIRTH: _____

SUBSCRIBER'S #_____ GROUP #_____

IF GROUP INSURANCE, THROUGH WHAT EMPLOYER? _____

DO YOU HAVE CO-PAY? YES NO AMOUNT OF CO-PAY _____

NAME OF SECONDARY INSURANCE COMPANY _____

SUBSCRIBER'S NAME_____ DATE OF BIRTH:

SUBSCRIBER'S # _____ GROUP # _____

IF GROUP INSURANCE, THROUGH WHAT EMPLOYER? _____

DO YOU HAVE CO-PAY? YES NO AMOUNT OF CO-PAY

We keep a record of the health care services we provide you. You may ask to see and copy the record. We will not disclose your record unless you direct us to do so or the law authorizes or compels us to do so.

I, the undersigned, have insurance coverage with _____ and/or
NAME OF COMPANY
_____ and assign directly to **PEACEHEALTH MEDICAL GROUP** all medical benefits
NAME OF COMPANY
if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: _____ Date:_____

AFFIX PATIENT LABEL HERE

DO NOT SCAN THIS FORM