EvergreenHealth

OBSTETRICS & GYNECOLOGY CARE, TAN

12333 NE 130TH LN #110 KIRKLAND, WA 98034

Registration For Medical Care

Name:_____
Last First M

Birthdate:_____/_____/_____ Age:_____

Marital Status: S M D W Sep
(circle one)

Patient Previous Name(s):_____

Ethnicity: Caucasian Indian Asian Hispanic African American
Native American Other: _____
(circle one)

Address:_____

Home Phone: (___)_____

City/State:_____ Zip:_____

Cell Phone: (____)_____

Employer: _____

Work Phone: (_____)_____

> I prefer calls on: ( ) Home ( ) Cell ( ) Work

Soc Sec Number: _____-_____-_____

Email Address: _____
Only to be used for purpose of correspondence from EWHC, will not be disclosed

Were you referred to our office ? _____ By Whom:_____ Primary Care Physician: _____

Health Insurance Plan Name _____ Subscriber name:_____

FAMILY INFORMATION

Husband/Partner/Parent Name: _____ Relationship to Patient: _____ Birthdate:_____/_____/_____

Employer: _____ Main Phone: (____)_____ Alternate Phone: (____)_____

Soc Sec: _____-_____-_____ If pt is a minor, with whom does child live ?_____

EMERGENCY CONTACT

Emergency Contact Name: _____ Main Phone: (_____)_____
(In addition to Family Info above)

Relationship to patient:_____ Alternate Phone: (_____)_____

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Please check all that apply:

( ) May release any health care information with the following person(s):_____

_____

( ) May release appointment information & financial information with the following person(s):_____

_____

( ) May leave a detailed message regarding any medical information on the voicemail at the following phone number(s) below:

> ( ) My phone number:_____ **( ) Other phone number:**_____

I may cancel this authorization in writing as allowed by law. There are three ways cancel this authorization: 1. Sign and date a revocation form. This form is available from Evergreen Womens Health Center; or 2. Write, sign and date a letter to Evergreen Womens Health Center to cancel the authorization; or 3. Sign, date and write "CANCEL" on this original form. Once Evergreen Womens Health Center gives out the information, the Evergreen Womens Health Center has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it. With this signature below, I understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing.

SIGNED: _____ **DATE:**_____

RELEASE OF INFORMATION: I authorize my insurance benefits to be paid directly to my doctor. I understand that I am financially responsible for any balances due. I authorize the doctor or insurance company to release any information required for the processing of insurance claims. I understand this may include information regarding HIV, sexually transmitted diseases, mental health, drug and/or alcohol use.

SIGNED: _____ **DATE:**_____