Olympic Medical Center

7715 24th Ave NW - Seattle, WA 98117
Ph: 206-782-1133 - Fax: 206-782-1373

PLEASE COMPLETE ALL SECTIONS

PATIENT NAME: DATE: ______________

____ ☐ Male ☐ Female

FIRST MIDDLE LAST

Name you prefer to be called:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Address: Apt # City Zip

Home Phone: ( ) Cell Phone: ( )

Social Security #:

Birthdate: Age:

Employer**:** **Occupation:**

Work Phone: ( )

Responsible Billing Party / Relationship to Patient: ☐ Self ☐ Partner / Spouse ☐ Child ☐ Parent
(give address and phone if different than above)

Address: Phone: ( )

Spouse or Partner's Name / Parent's name (if patient is a minor):

Spouse, Partner, or Parent's work phone: ( )

Whom shall we call in an emergency? (Please give name, address, area code and phone number of someone not living with you.)

Relationship to you:

Primary Medical Insurance Carrier: Member #:

Subscriber Name and Date of Birth: Group #:

Medicare Number:

Secondary or Medicare Supp. Insurance Carrier: Member #:

Subscriber Name and Date of Birth Group #:

Whom may we thank for referring you to our practice?
☐ Family/Friend Name: ____

☐ Mailer ☐ Yellow Pages ☐ Newspaper ☐ Internet ☐ Other: ____________________________

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I also authorize the doctor or insurance company to release information required for this claim.

If I have no insurance I agree to pay today for services provided by the physicians at Olympic Medical Center..

I, the patient / patient's legal representative, hereby grant permission to the physicians at Olympic Medical Center to perform such examinations and medical or therapeutic procedures as may be deemed professionally necessary for my / the patient's diagnosis and treatment.

I acknowledge receipt of Northwest Hospital & Medical Center's Notice of Privacy Practices.

Signature: ____________________________________ Date: ____________________