

PATIENT REGISTRATION FORM

If you need help filling out this form, please let us know.
(Please Print)

PATIENT INFORMATION				
Patient First Name	MI	Last Name	Date of Birth / /	Sex at Birth
Street Address		City	State	Zip
Mailing Address <input type="checkbox"/> Same as Above		City	State	Zip
Email Address	Home Phone Number ()	Cell Phone Number ()	Work Phone Number ()	
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse Name:	Date of Birth / /	Address: <input type="checkbox"/> Same as Above		Phone Number ()
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian Name:	Date of Birth / /	Address: <input type="checkbox"/> Same as Above		Phone Number ()
MEDICAL INSURANCE INFORMATION				
Person Responsible for Bill	Date of Birth / /	Address (if different)		Phone Number ()
Occupation	Employer		Employer Phone ()	
Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:				
Primary Medical Insurance:				
Subscriber Name	Policy #	Group #	Subscriber DOB / /	Co-pay \$
Secondary Medical Insurance:				
Subscriber Name	Policy #	Group #	Subscriber DOB / /	Co-pay \$
DENTAL INSURANCE INFORMATION				
Primary Dental Insurance:				
Subscriber Name	Policy #	Group #	Subscriber DOB / /	
IN CASE OF EMERGENCY				
Name of Friend or Relative	Relationship to Patient	Primary Number ()	Secondary Number ()	

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Unity Care NW. I understand that I am financially responsible for any balance. I also authorize Unity Care NW or my insurance company to release any information required to process my claims.

Signature: _____ Date: _____