Unity Care NW
Health Care for Everyone

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 / /	Age
Street Address	City	State	Zip	
Mailing Address □ Same as Above	City	State	Zip	
Email Address	Home Phone Number ( )	Cell Phone Number ( )	Work Phone Number ( )	
□ Parent □ Guardian □ Spouse Name:	Date of Birth / /	Address: □ Same as Above	Phone Number ( )	
□ Parent □ Guardian Name:	Date of Birth / /	Address: □ 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: □ Self □ Child □ Spouse □ Parent □ 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: _____