SEATTLE SPINE & SPORTS MEDICINE
PATIENT REGISTRATION

Welcome to our office. We are committed to providing comprehensive care. Please assist us by providing the following information. **Please carefully and legibly fill in the appropriate sections below.**

Patient Full Name	**Gender** ☐ **M** ☐ **F**	**SSN**	**Birthdate (MM/DD/YY)**
Home Address	City	State	Zip
Mailing Address ☐ **SAME AS MY HOME ADDRESS**	City	State	Zip
Primary Phone	**May we text you at this number?** ☐ **Y** ☐ **N**		**Email**
Interpreter Name	**Phone**		
Please specify **which physician or other health care provider** has referred you:	Primary Care Provider: ☐ **SEND THEM REPORT**		

EMERGENCY CONTACT

Name	Relationship to patient		
Address ☐ **SAME AS MY HOME ADDRESS**	City	State	Zip
Telephone: ☐ **HOME** ☐ **MOBILE** ☐ **WORK**			

PERSON RESPONSIBLE FOR PAYMENT

Name ☐ **SELF**	**Telephone**		
Address ☐ **SAME AS MY HOME ADDRESS**	City	State	Zip

PLEASE FILL OUT THIS SECTION IF THIS IS A CLAIM (e.g. MVA, L&I)

Please specify claim type: ☐ **MOTOR VEHICLE – PIP** ☐ **WORK-RELATED, Choose:** ☐ **STATE L&I** ☐ **Self-Insured L&I** ☐ **OTHER:**			
Date of Injury:	**CLAIM NUMBER:**	**Employer**	
Insurance Company Name	**Telephone**	**Adjuster's Name**	
Address	City	State	Zip
Attorney Name, if applicable	Telephone		
Briefly describe how & where injury occurred: (e.g.: driving; on the job; at home, etc)			

HEALTH INSURANCE (i.e. NOT CLAIM-RELATED)

Primary Insurance Company	Claim Address		
Subscriber's Name ☐ **SELF**	Birthdate	**Group No:**	**Primary** Insurance ID No.:
Secondary Insurance Company	Claim Address		
Subscriber's Name ☐ **SELF**	Birthdate	**Group No:**	**Secondary** Insurance ID No.:

Thank you for taking the time to fill this out.
Please Review & Sign Our Financial Policy Agreement