University of Washington Medical Center

Patient Registration Information

Please Print

Patient Name: Last	First	Middle	Social Security Number	Birthdate	Gender ☐M ☐F

Maiden Name	Permanent Mailing Address

Home phone ( )	Work phone ( )	Zip Code	City	State

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Last Name	First	Mailing Address			Relationship to patient
Home phone ( )	Work phone ( )	Zip Code:	City	State	

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Last Name	First	Home phone ( )	Work phone ( )	Relationship to patient

GUARANTOR

Last Name	First	Mailing Address			Relationship to patient
Home phone ( )	Work phone ( )	Zip Code	City	State	

MEDICAL INSURANCE

Primary Insurance Plan	Insurance Plan	Subscriber Name	Subscriber Employer (if applicable)	
	Subscriber Social Security Number	Patient Relationship to Subscriber	Subscriber Relationship to Guarantor	
Secondary Insurance Plan	Insurance Plan	Subscriber Name	Subscriber Employer (if applicable)	
	Subscriber Social Security Number	Patient Relationship to Subscriber	Subscriber Relationship to Guarantor	
Medicare	Medicare No	**Medicaid**	DSHS CASE No.	DSHS PIC No.

WORKER'S COMPENSATION CLAIMS

Employer Name at time of injury	Employer Phone: ( )	L&I Claim Number	Date of Injury / /

Mailing Address	Zip Code	City	State

Worker's Compensation Program ☐ State L&I ☐ Self-insured	Name of Claims Administrator	Case Manager

Additional Insurance Information to be completed if you did not bring your insurance card

Primary Insurance Plan	Name of Company or Program		Name of Benefit Plan
	Group Number	Subscriber Insurance ID #	Subscriber Relationship to Guarantor
	Insurance address		
Secondary Insurance Plan	Name of Company or Program		Name of Benefit Plan
	Group Number	Subscriber Insurance ID #	Subscriber Relationship to Guarantor
	Insurance address		