## **New Patient Registration Information**

PATIENT INFO	ORMATION											
Last Name F			First Name			Middle Name						
Social Security N	Date of Birth N			Name y	lame you preferred to be called/Alias							
Street Address				City				State Zip			Zip	
Home Phone Work Phone			Cell Phone			E	mail					
Marital Status Previous/Maiden Name			Written Language				Spoken Language					
Interpreter Needed?				VA Status ☐ Yes ☐ No			Race/Ethnicity (optional)					
Primary Care Pr	ovider (Name	and Phone)		Er	nployer Na	ame						
Emergency Contact Relat		Relation	Home F		hone	Work Phone		Э	Cell Pho		one	
Legal Next of Kin (if different) Relati			Home Phone			Work	Work Phone			Cell Phone		
RESPONSIBL	E PARTY IN	FORMATIC	N (if diffe	erent fro	m patien	nt)						
Last Name First N				Name			N	MI Alias or Maiden Name				
Social Security Number Gender Date				Date of Birth			F	Relationship to the Patient				
Street Address (	if different fror	n above)	I			City			State		Zip	
Home Phone Work Ph			Phone	ione			Cell Phone					
Employer Name				Occupatio			1			Status		
PRIMARY INS	URANCE									•		
				roup Number				Subscriber ID Number Copay				
Subscriber's Name S			Social Se	Social Security Number				Date of Birth Relationship to Patient				
Subscriber's Employer Name				Subscriber's Home Phone				Subscriber's Work Phone				
SECONDARY		E		•				1				
				oup Number							Copay	
Subscriber's Name			Social Se	Social Security Number			Date of Birth Relationship to Patien			nip to Patient		
Subscriber's Em		Subscriber's Home Pho			Ī	Subscriber's Work Phone						

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NEW PATIENT REGISTRATION INFORMATION Page 1 of 2

DO NOT SCAN OR FILE IN MEDICAL RECORD

DO NOT LABEL OR SCAN

## Is This Visit Related to Work Injury or Motor Vehicle Accident? If "yes", please complete the below.

☐ Work Related Injury										
Worker's Comp (Includes Labo	or & Industries)									
Employer:		D	Date of Injury:							
Body Part Injured and Description	on:		C	Claim Number:						
Adjuster/Claims Manager Name	ə:		Phone Number:							
Insurance Name:		Address:								
City:	State	-⊥ ∌/Zip:		L & I Claim Completed? Yes	No					
	L			L						
☐ Motor Vehicle Accident (PII	) Insurance									
Personal Injury Protection Insu	<u>ırance (Third Pa</u>	arty/Motor Ve	<u>:hicle)</u>							
Date of Injury:	of Injury: Body Part Injured and Description:									
Claim Number:	aim Number: Adjuster/Claims Manager Name:									
Adjuster Phone Number:		Insuran	nsurance Name:							
Insurance Address:										
City:			State/Zip:							
☐ Attorney Billing										
Attorney Information (Add'l Typ	pes/Special Phy	<u>ysician Svcs)</u>								
Attorney Name:	Law	Law Firm Name:								
Billing Address:										
City:	City:			State / Zip:						
Fax:	l	ate of Injury:								
Body Part Injured and Description	on:									

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**NEW PATIENT REGISTRATION INFORMATION** Page 2 OF 2

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