

New Patient Registration Information

PATIENT INFORMATION						
Last Name		First Name			Middle Name	
Social Security Number		Gender	Date of Birth		Name you preferred to be called/Alias	
Street Address			City		State	Zip
Home Phone		Work Phone		Cell Phone	Email	
Marital Status	Previous/Maiden Name		Written Language		Spoken Language	
Interpreter Needed?		VA Status <input type="checkbox"/> Yes <input type="checkbox"/> No		Race/Ethnicity (optional)		
Primary Care Provider (Name and Phone)			Employer Name			
Emergency Contact		Relation	Home Phone	Work Phone	Cell Phone	
Legal Next of Kin (<i>if different</i>)		Relation	Home Phone	Work Phone	Cell Phone	

RESPONSIBLE PARTY INFORMATION (if different from patient)						
Last Name		First Name			MI	Alias or Maiden Name
Social Security Number		Gender	Date of Birth		Relationship to the Patient	
Street Address (if different from above)			City		State	Zip
Home Phone		Work Phone		Cell Phone		
Employer Name			Occupation		Status	

PRIMARY INSURANCE						
Insurance Company Name		Group Number		Subscriber ID Number		Copay
Subscriber's Name		Social Security Number		Date of Birth	Relationship to Patient	
Subscriber's Employer Name			Subscriber's Home Phone		Subscriber's Work Phone	

SECONDARY INSURANCE						
Insurance Company Name		Group Number		Subscriber ID Number		Copay
Subscriber's Name		Social Security Number		Date of Birth	Relationship to Patient	
Subscriber's Employer Name			Subscriber's Home Phone		Subscriber's Work Phone	

DO NOT LABEL OR SCAN

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Neighborhood Clinics – Valley Medical Center
 University of Washington Physicians Seattle, Washington

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 TO THE MEDICAL RECORD**

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

Work Related Injury

Worker's Comp (Includes Labor & Industries)

Employer:		Date of Injury:	
Body Part Injured and Description:		Claim Number:	
Adjuster/Claims Manager Name:		Phone Number:	
Insurance Name:		Address:	
City:	State/Zip:	L & I Claim Completed? Yes No	

Motor Vehicle Accident (PIP) Insurance

Personal Injury Protection Insurance (Third Party/Motor Vehicle)

Date of Injury:	Body Part Injured and Description:		
Claim Number:	Adjuster/Claims Manager Name:		
Adjuster Phone Number:	Insurance Name:		
Insurance Address:			
City:	State/Zip:		

Attorney Billing

Attorney Information (Add'l Types/Special Physician Svcs)

Attorney Name:	Law Firm Name:		
Billing Address:			
City:	State / Zip:		
Fax:	Date of Injury:		
Body Part Injured and Description:			

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