

# ZHI-PING KOLOUCH, LAC

6300 9TH AVE NE, #200 ~ SEATTLE, WA 98115 (206) 522-5646

## PATIENT REGISTRATION

PLEASE FILL OUT COMPLETELY

Patient Name	MI:	Last:
Street Address:		
City:	State:	Zip:
SSN:	Gender: ( )M ( )F	Home ph: ( )
Employer:	Work ph: ( )	
Date of Birth: / /	Age:	Alt ph: ( )
Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other		
Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependant ( )Partnered ( )Other		
( )Parent / ( )Guardian / ( )Spouse / ( )Partner:	Phone: ( )	
Referred by:		
In case of emergency contact:	Relationship:	
Phone: ( )		

### PRIMARY INSURANCE

Insurance Company Name:	Phone: ( )
Claims Address:	
City, State, Zip:	
Subscriber's Name:	Date of Birth: / /
Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other	
I.D. # as shown on card:	Group #:
Employer of insured:	

### SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? ( )Y ( )N	Work related? ( )Y ( )N	Auto accident? ( )Y ( )N	State:
Insurance Company Name:	Phone: ( )		
Claims Address:			
City, State, Zip:			
Subscriber's Name:	Date of Birth: / /		
Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other			
I.D./ Claim # as shown on card:	Policy #:		
Employer if applicable:	Effective / Date of Injury: / /		

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee of up to \$50.00. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature \_\_\_\_\_

Date \_\_\_\_\_