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# Seattle Healing Arts Center

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## PATIENT REGISTRATION

PLEASE FILL OUT COMPLETELY

First Name:	MI:	Last:
Street Address:		
City:	State:	Zip:
Email:	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		
Responsible Party:		Phone: ( )
Address:		City, ST, ZIP:
In emergency contact:		Phone: ( )
Referred By:		

### PRIMARY INSURANCE

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

### SECONDARY INSURANCE

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

*I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. 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 \_\_\_\_\_