Snoqualmie Valley Clinic – Registration Form

Which provider do you wish to see today? ❑ Thomas Balch, ARNP ❑ Maurice Doerfler, MD ❑ Marybeth Lambe, MD

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Race White Black Hispanic Asian Pacific Islander Other	Birth date: / /	Age:	Sex: ❑ M ❑ F

Social Security no.:	Home phone no.: ( )	Cell Phone no.: ( )

Street address:	City:	State:	ZIP Code:
Mailing address:	City:	State:	Zip Code:

Email address:	Preferred pharmacy name & Location

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by:

Other family members seen here:

If patient is a minor, name of person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No Name of insurance plan:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-pay: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

CONSENT FOR CARE AND AGREEMENT TO PAY: I hereby consent to all medical or surgical treatment prescribed by the attending physician, or provider, and performance of all examinations, treatments, medications and procedures deemed necessary. I authorize the provider or their authorized staff, or the insurance company to release any information required for the processing of claims. I understand that I am financially responsible for any balance, regardless of insurance coverage.
ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to Snoqualmie Valley Clinic any insurance benefits payable for myself and/or covered member.

I have read the above and understand it's content.

Patient/Guardian signature *Date*