

# ASSOCIATED VALLEY OBSTETRICS AND GYNECOLOGY

Talbot Professional Center • 4011 Talbot Road South – Suite 430 • Renton, Washington • (425) 656-2496

## PATIENT REGISTRATION

PATIENT NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
\_\_\_\_\_ Cell Phone \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ May we leave messages on your answering machine? \_\_\_\_\_  
Social Security # \_\_\_\_\_ Sex: Male Female Marital Status: S M W D  
Email Address: \_\_\_\_\_  
Were you referred to us by a doctor? Yes No If so, by whom? \_\_\_\_\_

### PREFERRED PHARMACY:

Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

## EMPLOYER INFORMATION

PATIENT'S EMPLOYER \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_  
Address \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
\_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Spouse's Soc Sec # \_\_\_\_\_ DOB \_\_\_\_\_  
Patient's relationship to person responsible for bill: Self Spouse

## INSURANCE INFORMATION

Primary Insurance Name \_\_\_\_\_ Secondary Insurance Name \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_ Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Phone # \_\_\_\_\_  
Relationship to subscriber: Self Spouse Dependent Child Relationship to subscriber: Self Spouse Dependent Child

## EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY (PREFERABLY NOT LIVING AT SAME ADDRESS)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ DOB \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Primary: HM WK CELL

## ASSIGNMENT AND RELEASE

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I also understand that I will be charged a service charge of 1% per month (12% annually) on any amount outstanding 60 days past due.

SIGNED: \_\_\_\_\_

AUTHORIZATION OF TREATMENT OF A MINOR: I authorize Valley OB/GYN to treat the minor patient named above. It is our policy that the parent or guardian who requests treatment of a minor be financially responsible for the services rendered.

SIGNED: \_\_\_\_\_