



For office use:  
Patient ID:

## New Patient Registration

### PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname/AKA	Date of Birth
Mailing Address	City	State	Zip	Social Security
Home Address (if different)	City	State	Zip	
Home Phone	Cell Phone	Work Phone	Employer	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

### RESPONSIBLE PARTY INFORMATION

Relationship to patient	<input type="checkbox"/> Self (if self, skip to next section)	<input type="checkbox"/> Parent		
	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other _____		
Last Name	First Name	Middle Initial	Nickname/AKA	Date of Birth
Home Address	City	State	Zip	Social Security
Home Phone	Cell Phone	Work Phone	Employer	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

### PHYSICIAN REFERRAL INFORMATION

Primary Care Provider	Referring Physician	Preferred Pharmacy
How did you hear about us? (check all that apply)		
<input type="checkbox"/> Employer	<input type="checkbox"/> Family	<input type="checkbox"/> Friend
<input type="checkbox"/> Insurance	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Mail	<input type="checkbox"/> Area Map	<input type="checkbox"/> Physician
		<input type="checkbox"/> Radio

### INSURANCE INFORMATION

Insurance Company:	Copay:	Relationship To patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Parent
			<input type="checkbox"/> Spouse	<input type="checkbox"/> Other _____
Primary Insured Last Name	First Name	Middle Initial	Nickname/AKA	Date of Birth
Home Address	City	State	Zip	Social Security
Home Phone	Cell Phone	Work Phone	Employer	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

### EMERGENCY CONTACT INFORMATION (required)

Last Name	First Name	Relationship to patient	Home Phone	Cell Phone
Address	City	State	Zip	Work Phone
				Employer



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## NOTIFICATION BY PHONE

It is important to respect how you want to be notified of test results and referral appointments. Please check all of the following which apply:

Home Phone: (      )	Work phone: (      )
<input type="checkbox"/> Detailed messages may be left at this number	<input type="checkbox"/> Detailed messages may be left at this number
<input type="checkbox"/> Only a "call back" message may be left	<input type="checkbox"/> Only a "call back" message may be left
<input type="checkbox"/> Do not contact at this number except in an emergency	<input type="checkbox"/> Do not contact at this number except in an emergency

Cell phone: (      )	Other phone: (      )
<input type="checkbox"/> Detailed messages may be left at this number	<input type="checkbox"/> Detailed messages may be left at this number
<input type="checkbox"/> Only a "call back" message may be left	<input type="checkbox"/> Only a "call back" message may be left
<input type="checkbox"/> Do not contact at this number except in an emergency	<input type="checkbox"/> Do not contact at this number except in an emergency

## NOTIFICATION BY MAIL

- Use my home address (same as on registration form)
- Do NOT send mail to my home. Send all mail to my alternate mailing address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## DISCUSSING HEALTHCARE ISSUES

The following people are authorized to discuss my healthcare:

Name	Relationship
_____	_____
_____	_____
_____	_____

*Note: As the above information and relationships change, please keep us informed.*



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## Patient Authorization

### PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname/AKA	Date of Birth
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Definitions: "I", "me", and "my" mean the patient named above. The "Provider" means the provider, their affiliated entities and their employees.

Notice to Our Patients—Please be aware that as a walk-in clinic, we have no on-call service for after hours care. If you need medical attention during these times, you may call your primary care provider, or consider one of the following alternatives: For medical emergencies, call 911.

Emergency Rooms:	Anacortes	Mt. Vernon	Sedro Woolley
	Island Hospital	Skagit Valley Hospital	United General
	(360) 299-1300	(360) 856-6021	(360) 424-4111

Medicare Assignment of Benefits—I certify that the information I gave in applying for payment of Medicare benefits is correct. I assign Medicare benefits payable for provider services to the provider and I understand that I am responsible for any health insurance deductibles and co-insurance.

Financial Responsibility—I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for services rendered at this physician's office. I will honor the physician's office payment policy. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize payments to be made directly to the provider.

Insurance Assignment—I irrevocably assign and transfer to the provider's office all insurance benefits covering the provider's services (including health, liability, worker's compensation and any other insurance coverage) for the payment of services rendered. I understand that it is my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance copayments and deductibles.

Authorization for Care—I grant permission for the provider to render such care that my provider may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

Authorization for Release of Information—I hereby authorize Fidalgo Island Walk-In Clinic to release necessary information for the following reasons: to other medical providers for continuing professional care; to any insurance company or third party payer for the purpose of processing a claim or otherwise as allowed by law. I release the provider from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV and other diseases. This authorization is irrevocable and is not limited in time.

HIPAA Notice of Privacy Practices—The provider is required by applicable federal and state law to maintain the privacy of your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required to give you notice about our privacy practices and your rights concerning your PHI. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and applicable law permits the terms of this notice at any time, provided such changes are needed. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. By initialing this form, I confirm I have received and read a copy of the Notices of Privacy Practices.

I am signing this agreement to obtain services.

Signature of Patient or Representative	Relationship to Patient	Date
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