seattle fertility
ACUPUNCTURE

Glow Natural Health
2719 E. Madison St Suite 203
Seattle WA 98112
98116

The Healing Tree
3225 California Ave SW
Seattle WA

(206) 289 0692
www.fertilityacupuncturistseattle.com

PATIENT REGISTRATION

Please fill out completely

Patient First Name: MI: Last:

Street Address:

City: State: Zip:

Date of Birth: Age: Home ph:

Occupation: Work ph:

Gender: M F Transgender/Transman/FTM
Transgender/Transwoman/MTF
Cell ph:

Email:

Primary care provider:

Referred by: ☐ Doctor _____ ☐ Friend/family _____ ☐ Google ☐ Yelp ☐ Our Website ☐ Other _____

Employment: ☐ Employed ☐ F/T Student ☐ P/T Student ☐ Retired ☐ Unemployed ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Dependent ☐ Other

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 ☐Dependent ☐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 ☐Dependent ☐Other

I.D./Claim # **as shown on card:** Policy#:

Employer if applicable: Injury Date:

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the health care provider 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 health care provider.

Signature _____ **Date** _____

Office use only: *Entered/ Faxed on:*_____