

**Roger K. Larson, MD**  
**PATIENT REGISTRATION FORM**

Dates Reviewed & Updated: \_\_\_\_\_

**PLEASE PRINT**

PT. NAME _____			M _____ F _____	DOB _____	AGE _____
Last	First	MI	SS# _____		
ADDRESS _____			MARITAL STATUS _____		
CITY/STATE _____		ZIP _____	OCCUPATION _____		
HOME PHONE ( _____ ) _____			EMPLOYER _____		
SPOUSE'S NAME _____			ADDRESS _____		
SPOUSE'S DOB _____			WORK PHONE ( _____ ) _____		
REFERRED BY _____			PRIMARY CARE PHYSICIAN _____		

<b>PRIMARY INSURANCE</b> _____		<b>SECONDARY INSURANCE</b> _____	
Insured _____	DOB _____	Insured _____	DOB _____
Employer _____		Employer _____	
Relationship to patient _____		Relationship to patient _____	
Insured ID No. _____		Insured ID No. _____	
Group No. _____		Group No. _____	
If Labor and Industries: Claim # _____ Date of Injury _____ Employer at time of injury _____			
<b>Does your insurance require preauthorization before hospitalization or procedures?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
If YES, phone number to call: _____			

**BILLING:** If person responsible for bill is **other than above patient**, please complete.

NAME _____			SS# _____		
Last	First	MI	OCCUPATION _____		
Relationship to patient _____			EMPLOYER _____		
ADDRESS _____			ADDRESS _____		
CITY/STATE _____		ZIP _____	CITY/STATE _____		ZIP _____
HOME PHONE ( _____ ) _____			WORK PHONE ( _____ ) _____		

**EMERGENCY INFORMATION:** Person to contact in case of emergency, not living at the above address.

NAME _____		RELATIONSHIP TO PATIENT _____	
ADDRESS _____		PHONE # _____	
CITY/STATE _____		ZIP _____	

**Please read the following statement carefully before signing.**

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have also been informed of the **\$35.00 fee (per RCW 62A.3-515&520) on checks returned from my bank NSF**. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with **1% interest per month (per RCW 19.52)** on the unpaid balance.

SIGNATURE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

DATE \_\_\_\_\_