Today's Date:	

REGISTRATION FORM

Patient

Name (Last, First, M.I.):			Maiden name:	
		DOB:		☐ M ☐ F
Street Address	City		St	Zip
Preferred Contact Number: ☐ Home ☐ Work ☐ Cell				
Home Phone	Work Phone	Cell Phone		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Emergency Contact and Phone:			

Employer

Employer Name
Employer Address

Primary Insurance

Insurance Company Name:		Co-pay:
Subscriber's ID:		Group Number:
Subscriber's Name:		Subscriber's employer:
Subscriber's DOB:	Subscriber's sex: ☐ M ☐ F	Relationship to Subscriber:

Secondary Insurance

Insurance Company Name:		Co-pay:
Subscriber's ID:		Group Number:
Subscriber's Name:		Subscriber's employer:
Subscriber's DOB:	Subscriber's sex: ☐ M ☐ F	Relationship to Subscriber:

Responsible Party (who is in responsible for any balances on this account?)

☐ Self ☐ Parent ☐ Guardian ☐ L & I ☐ Worker's Comp. ☐ Employer Contract

	Name (Last, First, M.I.):			
Street Address	City		St	Zip
Home Phone	Work Phone	Cell Phone		
Worker's Compensation/ L&I Claim Number:			Date of Injury:	
Employer Name:				

Referred By (how were you referred to the Institute of Complementary Medicine?)

☐ Insurance directory ☐ Website ☐ Yellow pages ☐ Friend ☐ Relative ☐ Physician

Whom may we thank? Name

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic.

Signature:	Date: