Institute of Complementary Medicine
1600 E Jefferson Street, Suite 603
Seattle, WA 98122-5649

Demographics- ICM 2019

REGISTRATION FORM

Personal Details

First Name *

Last Name *

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Extn _____

Primary Phone ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

May we leave extended messages on your voicemail? * ☐ Home ☐ Mobile ☐ Do not leave extended messages ☐ Others _____

Please list any person(s) we may speak to regarding scheduling appointments. * _____

_____

_____

Please list any person(s) we may speak to regarding billing questions. * _____

_____

_____

_____

Insurance Company Name: _____

Subscriber's ID _____

Subscriber's Name _____

Subscriber's DOB _____

Subscriber's sex ☐ M ☐ F

Co-pay _____

Group Number _____

Subscriber's employer _____

Relationship to Subscriber _____

Responsible Party (who is in responsible for any balances on this account?)
☐ Self ☐ Parent
☐ Guardian ☐ Auto

Name (Last, First, M.I.) _____

Street Address _____

City, State, Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Auto Accident Claim Number _____

Date of Injury _____

Referred By (how were you referred to the Institute of Complementary Medicine?)
☐ Insurance directory ☐ Website
☐ Yellow pages ☐ Friend
☐ Relative ☐ Physician

Whom may we thank? Specify the 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 : _____

Today's Date _____