1402 Lake Tapps Pkwy E. Ste. F106
Auburn WA 98092
Phone: 253-288-8882
Fax: 253-288-2283

TODAY'S DATE _____

PATIENT REGISTRATION

Patient's Name _____
(First) (Middle) (Last)
Address _____ (City/State/Zip) ____ / ____ / _____

Phone ___-___-____ ___-___-____ ___-___-____
(Home) (Work) (Cell)
Date of Birth ___/___/___ SSN ___-___-____ Sex M□ F□ Marital Status S □M □ D□ W □
Employment: □Full-Time □ Part-Time □ Student □ Unemployed Employer _____ Phone ___-___-____

Guarantor: Who is financially responsible for you? □ Parent □ Other _____ (Skip if you are over 18)

Guarantor's Name_____
(First) (Middle) (Last)
Address _____ (City/State/Zip) ____ / ____ / _____

Phone ___-___-____ ___-___-____ ___-___-____
(Home) (Work) (Cell)
Date of Birth ___/___/___ SSN ___-___-____ Sex M□ F□ Marital Status S □M □ D□ W □
Employment: □Full-Time □ Part-Time □ Student □ Unemployed Employer _____ Phone ___-___-____

Insurance Information (Primary) Who is the insured party? □ Self □Spouse □ Parent □ Other

Insured's Name_____
(First) (Middle) (Last)
Address _____ (City/State/Zip) ____ / ____ / _____

Phone ___-___-____ ___-___-____ ___-___-____
(Home) (Work) (Cell)
Date of Birth ___/___/___ SSN ___-___-____ Sex M□ F□ Marital Status S □M □ D□ W □
Employment: □Full-Time □ Part-Time □ Student □ Unemployed Employer _____ Phone ___-___-____

Insurance Information (Secondary) Who is the insured party? □ Self □Spouse □ Parent □ Other

Insured's Name_____
(First) (Middle) (Last)
Address _____ (City/State/Zip) ____ / ____ / _____

Phone ___-___-____ ___-___-____ ___-___-____
(Home) (Work) (Cell)
Date of Birth ___/___/___ SSN ___-___-____ Sex M□ F□ Marital Status S □M □ D□ W □
Employment: □Full-Time □ Part-Time □ Student □ Unemployed Employer _____ Phone ___-___-____

Emergency Contacts

Name _____ Relationship _____ Phone ___-___-____ C □H □
Name _____ Relationship _____ Phone ___-___-____ C □H □

Authorization for treatment, release of information, assignment of insurance benefits, and notice of privacy policies I give my consent for services provided by Access Healthcare. I also hereby authorize my insurance benefits to be paid directly to Access Healthcare and am financially responsible for non-covered services. I authorize Access Healthcare to release to my insurance company any information needed and required for payment. By my signature I acknowledge the notice of privacy statement has been made available to me.

Signature _____ **Print Name** _____