

## New Patient Registration Information

PATIENT INFORMATION					
Last Name		First Name		Middle Name	
Social Security Number	Gender	Date of Birth	Name you preferred to be called/Alias		
Street Address			City	State	Zip
Home Phone	Work Phone	Cell Phone	Email		
Marital Status	Previous/Maiden Name	Written Language		Spoken Language	
Interpreter Needed?		VA Status <input type="checkbox"/> Yes <input type="checkbox"/> No	Race/Ethnicity (optional)		
Primary Care Provider (Name and Phone)			Employer Name		
Emergency Contact	Relation	Home Phone	Work Phone	Cell Phone	
Legal Next of Kin (if different)	Relation	Home Phone	Work Phone	Cell Phone	

RESPONSIBLE PARTY INFORMATION (if different from patient)					
Last Name		First Name		MI	Alias or Maiden Name
Social Security Number	Gender	Date of Birth	Relationship to the Patient		
Street Address (if different from above)			City	State	Zip
Home Phone	Work Phone		Cell Phone		
Employer Name		Occupation		Status	

PRIMARY INSURANCE			
Insurance Company Name	Group Number	Subscriber ID Number	Copy
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient
Subscriber's Employer Name		Subscriber's Home Phone	Subscriber's Work Phone

SECONDARY INSURANCE			
Insurance Company Name	Group Number	Subscriber ID Number	Copy
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient
Subscriber's Employer Name		Subscriber's Home Phone	Subscriber's Work Phone

DO NOT LABEL OR SCAN

**UW Medicine**  
 Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians      Seattle, Washington

**NEW PATIENT REGISTRATION INFORMATION**

Page 1 of 2

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 IN MEDICAL RECORD**

**Is This Visit Related to Work Injury or Motor Vehicle Accident?**  
*If "yes", please complete the below.*

**Work Related Injury**

Worker's Comp (Includes Labor & Industries)

Employer:		Date of Injury:	
Body Part Injured and Description:		Claim Number:	
Adjuster/Claims Manager Name:		Phone Number:	
Insurance Name:		Address:	
City:	State/Zip:	L & I Claim Completed?    Yes    No	

**Motor Vehicle Accident (PIP) Insurance**

Personal Injury Protection Insurance (Third Party/Motor Vehicle)

Date of Injury:	Body Part Injured and Description:		
Claim Number:	Adjuster/Claims Manager Name:		
Adjuster Phone Number:	Insurance Name:		
Insurance Address:			
City:	State/Zip:		

**Attorney Billing**

Attorney Information (Add'l Types/Special Physician Svcs)

Attorney Name:	Law Firm Name:		
Billing Address:			
City:	State / Zip:		
Fax:	Date of Injury:		
Body Part Injured and Description:			

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 University of Washington Physicians  
 Seattle, Washington

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**Page 2 OF 2**

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