12811 8th Ave. W., Ste. A-205, Everett, WA 98204 (425) 348-1259

Patient Information

Last Name ______________________________ First Name _________________ Middle ________________ SS# _______ - _____ - __________

Street Address ____ City _____________________ State ______ Zip Code _____________

Mailing Address(if different from above) ____________________________________ City _________________ State ______ Zip Code ____________

Home Phone _____ -_______ - __________ Birthdate ______________ Age ______ Sex M F Height _____' ______" Weight ________lbs

Cell Phone _____ -_______ - __________ Marital Status M S D W Your E-mail address ____

Driver's License State & Number _________________________

Emergency Contact ________________________________ Phone _____ -_______ - __________ Relationship ______________

WORK STATUS: Employed Retired Full Time Student Part Time Student Other ___________________________

Occupation _______________________ Employer _______________________________ Work Phone ________ - ________ - ________________

Employer Address ____ City _______________________ State _______ Zip Code_____________

Spouse Full Name ____________________________________ Spouse SS# ________ - _____ - __________ Birthdate _____________________

Spouse Occupation ____________________ Spouse Employer __________________________ Spouse Work Phone _______________________

Insurance Information (please read below –there are separate sections to match the type of insurance you would like us to bill)

PRIMARY INSURANCE NAME _______________________________________ Subscriber Full Name ____________________________________

Subscriber Member # ___________________________________ Group # ___________________ Subscriber Birthdate ___________________________

Insurance Phone # ___________________________________ Employer of Subscriber____

Patient's Relationship to Subscriber Spouse Child Other ____

SECONDARY INSURANCE *Upon request, we will provide you with a billing statement appropriate for you to submit to your insurance company.*

IS THIS A WORK RELATED INJURY? Yes No Date of Injury ____________ Employer at time of injury ________________________

L&I Claim Number _________________________ Billing Address ____

Claim Representative Name ____ Claims Rep Phone ____________________________________

IS THIS INJURY DUE TO A MOTOR VEHICLE ACCIDENT? Yes No Date of injury _____________ State where accident occurred __________

Did the accident occur in your vehicle? Yes No Were You Driver Passenger

Do you have Personal Injury Protection (PIP) coverage? Yes No PIP Insurance Claim # ____

Policy Holder _____________________________________ Relationship to Policy Holder Self Spouse Child Other ___________________

Your Auto Ins Carrier _________________________ Billing Address ____

PIP Claims Rep ____ Claims Rep Phone __________________________________

AUTHORIZATION AND ASSIGNMENT OF BENEFITS I hereby authorize you to evaluate and treat me and I assign all medical benefits to **PUGET Orthopedic Rehabilitation (POR)**. I hereby authorize release of all information to secure payment. A photocopy shall be considered valid.

SIGNATURE ____ **DATE** ______________________