UW Medicine
VALLEY MEDICAL CENTER

VALLEY MEDICAL CENTER – CLINIC NETWORK
REGISTRATION FORM
(Please Print)

Office Use Only
Patient Note(s): ____________

YOUR PREFERRED PHYSICIAN'S NAME: ____________________

PATIENT INFORMATION

LAST NAME: ____________ FIRST ____________ MI ______ SSN#____________

Sex: ☐ Male ☐ Female Date of Birth Month_______Day_________Year____

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former or alternate name):

Mailing Address/Apt#	City:	State:	Zip:
Home Address (if different than mailing address)	City:	State:	Zip:

Home Phone:	Work Phone & Extension	Mobile Phone	E-Mail Address

Need Interpreter ☐Yes ☐No Spoken Language____________ Written Language____________	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Reg Domestic Partner ☐ Life Partner	Religion

Racial Designation/Ethnicity: **OPTIONAL** information for Federal statistics, program administrative reporting, and civil rights compliance reporting only. Please mark one or more:
☐ ALASKAN NATIVE ☐ NATIVE AMERICAN ☐ ASIAN ☐ AFRICAN-AMERICAN or BLACK ☐ CAUCASIAN or WHITE ☐ HISPANIC or LATINO
☐ NATIVE HAWAIIAN ☐ PACIFIC ISLANDER ☐ MIXED RACE ☐ OTHER

IN CASE OF EMERGENCY CONTACT

Name of local friend or relative: (Not living at same address):	Relationship to patient:	Home Phone ( )	Work Phone ( )	Cell Phone ( )

Address	City	State	Zip

LEGAL GUARDIAN
(If different from Responsible Party Below)

NAME: Last: ____________ First: ____________ MI: _______ Birth date: ____________

How did you hear about us? Mark one: ☐ Friend/Family Member ☐ Physician ☐ Physician Referral Line ☐ TV ☐ Radio ☐ Newspaper/Magazine ☐ Internet ☐ Attorney ☐ Special Event ☐ Other: ____________

Driver's License No ____________

Employer	Occupation	Date Started	Employer Phone: ( )

Employment Status (Age 18 & over) Mark one: ☐ Full time ☐ Part time ☐ Retired ☐ Not employed ☐ Self-employed ☐ Active Military Duty ☐ Student Status: ☐ Full time ☐ Part time

RESPONSIBLE PARTY INFORMATION
(Person Responsible for payment of account if patient is under age 18)

RESPONSIBLE PARTY'S NAME: Last: ____________ First: ____________ MI: ______ SSN#____________

Mailing/Billing Address:	City:	State:	Zip:

Responsible Party's Relationship to Patient ☐ Spouse ☐ Parent ☐ Other: ____________	Is this person a patient here? ☐ Yes ☐ No	Sex: ☐ Male ☐ Female Date of Birth Month_______Day______Year______

Home phone: ( )	Work phone: ( )	Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Not employed ☐ Self-employed ☐ Active Military Duty ☐ Student Status(Age 18-23 only): ☐ Full time ☐ Part time

Employer's Name:	Employer Address:	Employer Phone: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PRIMARY INSURANCE - Subscriber Information

Is this patient covered by insurance? ☐ Yes ☐ No (If no, please refer to Financial Policy)

Subscriber's Name: Last:__________________________ First: _________________	**Subscriber SSN:** – –	**Subscriber's Sex:** ☐ Male ☐ Female **Date of Birth** Month______Day______Year______

Subscriber's Address (if different from patients):	**City:**	**State:**	**Zip:**

Home phone: ( )	**Work phone:** ( )	**Employment Status:** ☐ Full time ☐ Part time ☐ Retired ☐ Not employed ☐ Self-employed ☐ Active Military Duty ☐ Student Status: ☐ Full time ☐ Part time

Subscriber's Employer's Name:	**Employer Address:**	**Employer Phone:** ( )

Please indicate Primary Insurance CO	☐ AETNA ☐ CIGNA ☐ DSHS *(Please provide coupon)* ☐ FIRSTCHOICE ☐ MOLINA*(HO Please provide coupon and card)* ☐ MEDICARE ☐ PREMERA ☐ PACIFICARE/SECUREHORIZONS ☐ REGENCE ☐ UHC ☐ Other: _______________

Insurance Claims to Address	**City**	**ST**	**ZIP**

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Group#:**	**Policy/ Subscriber Identification #:**	**Subscriber's Group Name:**

(Patient's) Member ID (if different from subscriber's):	**INS Effective Date:**	**Co-payment: $**

SECONDARY INSURANCE – Subscriber Information

Is this patient covered by insurance? ☐ Yes ☐ No (If no, please refer to Financial Policy)

Subscriber's Name: Last:__________________________ First: _________________	**Subscriber SSN:** – –	**Subscriber's Sex:** ☐ Male ☐ Female **Date of Birth** Month______Day______Year______

Subscriber's Address (if different from patients):	**City:**	**State:**	**Zip:**

Home phone: ( )	**Work phone:** ( )	**Employment Status:** ☐ Full time ☐ Part time ☐ Retired ☐ Not employed ☐ Self-employed ☐ Active Military Duty ☐ Student Status: ☐ Full time ☐ Part time

Subscriber's Employer's Name:	**Employer Address:**	**Employer Phone:** ( )

Please indicate Primary Insurance CO	☐ AETNA ☐ CIGNA ☐ DSHS *(Please provide coupon)* ☐ FIRSTCHOICE ☐ MOLINA*(HO Please provide coupon and card)* ☐ MEDICARE ☐ PREMERA ☐ PACIFICARE/SECUREHORIZONS ☐ REGENCE ☐ UHC ☐ Other: _______________

Insurance Claims to Address	**City**	**ST**	**ZIP**

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Group#:**	**Policy/ Subscriber Identification #:**	**Subscriber's Group Name:**

(Patient's) Member ID (if different from subscriber's):	**INS Effective Date:**	**Co-payment: $**