

**NORTHWEST MEDICAL GROUP**

Date: \_\_\_\_\_  
Account: \_\_\_\_\_  
Chart: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**PATIENT REGISTRATION INFORMATION**

Patient: SSN: DOB:  
Address: Sex: Phone:  
City: St: Zip: Cell:  
Marital Status: Employer/School: Emp. Phone:

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**Responsible Party (Only if Patient is a Dependent)**

Name: SSN: DOB:  
Address: Sex: Phone:  
City: St: Zip:  
Relation to Pt: Employer:

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**Emergency Contact/Guardian**

Name: Phone:  
Address: Relation to Pt:  
Guardian Name:

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**Insurance Information-Primary**

Company: Group: ID:  
Subscriber: SSN: DOB:  
Address: Sex: Phone:  
City: St: Zip: Copay:  
Relation to Pt: Employer:

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**Insurance Information-Secondary**

Company: Group: ID:  
Subscriber: SSN: DOB:  
Address: Sex: Phone:  
City: St: Zip: Copay:  
Relation to Pt: Employer:

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This Office will bill all HMO and PPO contracted payers-copayments and/or Deductibles must be paid at time of visit.

I authorize the release of any medical information necessary to process my claim. I also authorize payment of medical benefits to the physicians or suppliers of services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible within a 30 day period for all charges whether or not paid by said insurance. I hereby authorize said insurance to release information necessary to secure payment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_