

PLEASE PRINT

PATIENT REGISTRATION RECORD



Northwest Radiology Group, LLC
500 Lilly Rd., NW Suite 160 • Olympia, WA 98506
Phone 360-413-8383 • Fax 360-413-8323

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PATIENT'S NAME:		LAST	FIRST	MIDDLE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
PRESENT ADDRESS:		STREET (AND APT. NO)		CITY	STATE	ZIP CODE
MAILING ADDRESS:		(IF DIFFERENT)				
SOCIAL SECURITY NUMBER:		HOME PHONE		WORK / CELL PHONE		
EMPLOYER				CITY		
IF PATIENT HAS EVER BEEN KNOWN UNDER A DIFFERENT NAME, LIST						

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PRIMARY INS CO. _____	SECONDARY INS CO. _____
EFFECTIVE DATE _____	EFFECTIVE DATE _____
SUBSCRIBER _____	SUBSCRIBER _____
SUBSCRIBER SS# _____	SUBSCRIBER SS# _____
SUBSCRIBER ID _____	SUBSCRIBER ID _____
GROUP # _____	GROUP # _____
RELATIONSHIP TO PATIENT _____	RELATIONSHIP TO PATIENT _____
WORK PHONE NUMBER OF INSURED _____	WORK PHONE NUMBER OF INSURED _____
SUBSCRIBER'S BIRTHDATE _____	SUBSCRIBER'S BIRTHDATE _____
IS THIS A WORK RELATED INJURY? YES / NO	IS THIS A MOTOR VEHICLE ACCIDENT? YES / NO
DATE OF INJURY _____	DATE OF INJURY _____
CLAIM # _____	

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<input type="checkbox"/> HUSBAND	NAME:	LAST	FIRST	MIDDLE	DATE OF BIRTH
<input type="checkbox"/> FATHER OF PATIENT (IF MINOR)		STREET (AND APT NO)		CITY	STATE
ADDRESS:					ZIP CODE
EMPLOYER:				CITY	BUSINESS PHONE
<input type="checkbox"/> WIFE	NAME:	LAST	FIRST	MIDDLE	DATE OF BIRTH
<input type="checkbox"/> MOTHER OF PATIENT (IF MINOR)		STREET (AND APT NO)		CITY	STATE
ADDRESS:					ZIP CODE
EMPLOYER:				CITY	BUSINESS PHONE

CONTACT OUTSIDE OF THE HOME _____ PHONE _____

AUTHORIZATION	
I AUTHORIZE NORTHWEST RADIOLOGY GROUP, LLC TO RELEASE ANY MEDICAL INFORMATION WHICH MAY BE REQUIRED TO PROCESS CLAIMS FOR PAYMENT OF MEDICAL SERVICES THROUGH INSURANCE CARRIER, PREPAID MEDICAL PLAN, OR GOVERNMENT AGENCY.	
PATIENT'S SIGNATURE _____	DATE _____
OR	
SIGNED BY _____	<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER (SPEC) _____

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