Nicole B. White, MD
1560 N 115th St, Ste 102 – Seattle, WA 98133
206-368-1070

PATIENT REGISTRATION FORM

PATIENT NAME: DATE:

_____
Last *First* *MI* ☐ Male ☐ Female

Name you prefer to be called:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Birth date: Age: Social Security #:

Address: Apt: City: Zip:

Home Phone: ( ) Cell Phone: ( )

Email Address:

Employer: Work Phone: ( )

Primary Physician: Phone: ( )

Referring Physician: Phone: ( )

Responsible Billing Party / Relation to Patient: ☐ Self ☐ Partner/Spouse ☐ Child ☐ Parent
(Please give address and phone if different from above)

Address: Phone: ( )

Emergency Contact: _____ Relation: _____
Day Phone: ( ) Evening Phone: ( )

Primary Insurance Carrier: _____ Member ID#: _____

Subscriber Name / Date of Birth: _____ Group #: _____

Secondary Insurance Carrier: _____ Member ID#: _____

Subscriber Name / Date of Birth: _____ Group #: _____

I have no insurance. I agree to pay today for the services provided by Nicole B. White, MD

Signature: Date:

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I understand that any and all non-covered services are my sole financial responsibility. I also authorize the doctor or insurance company to release information required for this claim. I also understand that if my insurance requires a referral, it is my responsibility to provide one to Nicole B. White, MD at the time of service.

I, the patient/patient's legal representative, hereby grant permission to Nicole B. White, MD to perform such examinations and medical or therapeutic procedures as may be deemed professionally necessary for my/the patient's diagnosis and treatment.

I acknowledge receipt of Northwest Hospital & Medical Center's *Notice of Privacy Practices.*

Signature: Date: