NWSPINE
Northwest Spine & Laser Surgery Center

REGISTRATION FORM

(Please Print and provide as much information as possible)

Today's date

PATIENT INFORMATION

Patient's last name	Middle Initial	First

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Marital Status ❑ M ❑ S ❑ D ❑ W	Birthdate / /	Age	Sex ❑ M ❑ F

Street Address

City State & Zip

Home Phone	Cell Phone	Preferred Contact Number	Email Address

Social Security Number	Occupation

Employer	Employer City/State	Work Phone

RESPONSIBLE PERSON / RIDE INFORMATION

Name of person giving you Transportation/Ride today	Relationship to patient	Cell or Home phone numbers to reach at any time while patient is in Center

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Home phone	Work phone

I hereby authorize release of my personal medical information to the following and their Relationship to me:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Oregon State Reporting

Please check the box(es) that are applicable

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ White
- ❑ Other:_____
- ❑ I decline to answer
- ❑ Hispanic or Latino Ethnicity
- ❑ Non-Hispanic or Latino Ethnicity
- ❑ I decline to answer

PATIENT STICKER

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PRIMARY INSURANCE

(Please provide your insurance card and ID to the receptionist.)

Name of Primary Insurance Provider		
Subscriber's name	Birthdate / /	Relationship to Patient
Policy Number		Group Number

SECONDARY INSURANCE

Name of Secondary Insurance Provider		
Subscriber's name	Birthdate / /	Relationship to Patient
Policy Number		Group Number

WORKER'S COMPENSATION OR L&I INSURANCE

Name of Worker's Compensation Fund			
Group Number	Policy Number		Claim Number
Name of Employer where Injury Occurred			Date of Injury
Agent	Phone Number		Extension
Attorney Name/Firm			
Address	Phone Number		

MOTOR VEHICLE ACCIDENT / THIRD PARTY LIABILITY / LAWSUIT

Date of Injury	MVA Insurance Carrier Name	
Claim #	Address	
Claim Status, i.e., Open, Closed, Litigation		
City State and County where incident occurred		Name of Person who injured you
Name of Adjuster/Agent	Phone Number/Extension	
Name of Attorney/Firm	Phone Number	

SIGNATURES: **The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Center. I understand that I am financially responsible for any balance. I also authorize NORTHWEST SPINE AND LASER SURGERY CENTER or insurance company to release any information required to process my claims.**

_____ _____

Patient/Guardian signature ***Date***