

Whidbey Community Physicians

275 S.E. Cabot Drive Suite B 101, Oak Harbor, Washington 98277

Date _____

Patient Acct. # _____

PATIENT INFORMATION

Mr./Ms. _____

Home Phone _____

Mrs./Miss _____ Last _____ First _____ M.I. _____

Work Phone _____

Address _____

Employer _____

City _____ State _____ Zip _____

Would you like to be contacted via email for lab results, appts., etc. Y N

Social Security # _____

Email _____

Birthdate _____ Sex: M F

Marital Status: Single Married Other

Primary Care Physician _____

Employment/student status: Employed FULL PART

Allergies _____

Emergency Contact Person _____

Current Medication _____

Phone Number _____

INFORMATION FOR PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE (GUARANTOR)

Mr./Ms. _____

Guarantor Home Phone _____

Mrs./Miss _____ Last _____ First _____ M.I. _____

Guarantor Work Phone _____

Social Security # _____

Relation to Patient _____

Address _____

Employer _____

City _____ State _____ Zip _____

IS THE PATIENT COVERED BY MEDICAL INSURANCE?

YES

NO

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE**	OTHER INSURANCE
Insurance name			
Subscriber's name			
Subscriber's employer			
Subscriber's ID# or SS#			
Group, member #, or claim #			
Subscriber's birthdate & sex: M F			
Subscriber's address if different from patient			
Subscriber's phone if different from patient			
Co-payment required			
Relation of patient to subscriber			
Subscriber's work phone			

** MEDICARE PATIENTS ONLY

PLEASE CHECK APPROPRIATE BOX

SUPPLEMENTAL INSURANCE IS PROVIDED BY PATIENT (MG)

SUPPLEMENTAL INSURANCE IS PROVIDED BY EMPLOYER (SP)

AGREEMENT: Responsibility for payment on this account remains with me, regardless of insurance coverage. Unless other arrangements have been made, payment is expected at the time of service. If arrangements have been made for monthly billing, payment is due IN FULL within 30 days of billing date. Past due accounts (over 30 days) will be assessed a monthly late charge of 1.0% of the outstanding balance or a minimum of \$2.00. I agree to final responsibility of my account.

I request payment of authorized benefits to me, or on my behalf, for any services furnished to me be payable to the Whidbey Community Physicians. I authorize any holder of medical information about me to release to my Insurance Company any information needed to determine these benefits or benefits for related services. Professional providers who submit claims on the basis of an institution's signature-on-file should include the name of the institutional provider that maintains the signature on file.

Date _____

Signature _____

WCP-26035