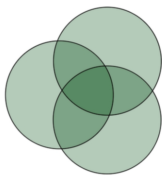

office 206-906-9786
fax 206-906-9246
EHR fax 206-902-2008
info@deanchiermd.com

Lake City Professional Center
2611 NE 125th St., Ste 90
Seattle, WA 98125
www.deanchiermd.com

NEW PATIENT REGISTRATION

Please fill out completely

First Name: MI: Last Name:

Street Address: City, State, Zip:

Email: Date of Birth:

Employer: Mobile Phone #: ( ) MSG OK? ( ) YES ( ) NO

Gender Identity: Home Phone #: ( ) MSG OK? ( ) YES ( ) NO

Work Phone #: ( ) MSG OK? ( ) YES ( ) NO

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependent ( )Partnered ( )Other

Responsible Party: Phone: ( )

Address: City, ST, ZIP:

Emergency Contact: Email: Phone: ( )

Referred By:

PRIMARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth**:

Relationship to You: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

SECONDARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth**:

Relationship to You: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: **Date:**