1530 N 115th St. #302
Seattle, WA 98133
T: 206-355-6781
F: 206-365-0663

13433 NE 20th ST. #D
Bellevue, WA 98005
T: 425-451-4301
F: 425-957-1406

15228 Woods Creek RD. SE
Monroe, WA 98272
T: 206-355-6781
F: 425-957-1406

CONFIDENTIAL PATIENT REGISTRATION FORM

Patient Information

Date_____

Name: _____ I Prefer to be called: _____
Address: _____City:_____State:_____Zip_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Date of Birth: _____ Social Security Number: _____ ☐ Male ☐ Female
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Occupation _____
Employer _____ Work Phone _____
Spouse or Parent's Name:_____ Social Security Number _____
Occupation _____Employer _____ Work Phone _____
Email Address_____

Payment/Insurance

Insurance (Primary)_____
Insurance (Secondary)_____
Person responsible for payment:_____
Referred By: _____
Your Family Physician:_____Phone (____)_____
***If an auto accident, please provide:**
Insurance Company Name_____ Claim #_____
Contact Person_____Phone #_____
I authorize payment of benefits to Jacob Khesin, LMPC for medical services I have received.

Signature:_____**Date:**_____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or Jacob Khesin, LMPC.

Signature:_____**Date:**_____

Emergency Information

Contact #1_____Relationship_____ Phone #_____
Contact #2_____Relationship _____ Phone #_____