

**PATIENT REGISTRATION**

Patient Name (including Middle): \_\_\_\_\_ Home: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ M \_\_\_ F \_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City, State, ZIP: \_\_\_\_\_ Age: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ cell# \_\_\_\_\_ work# \_\_\_\_\_  
Emergency Contact (relation): \_\_\_\_\_ Phone: \_\_\_\_\_  
Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent or Guardian: \_\_\_\_\_ Phone : \_\_\_\_\_  
(IF under 18 or disabled)  
Primary Care Doctor: \_\_\_\_\_ Referring Physician : \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance : \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber/Member ID # \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Group # \_\_\_\_\_  
(if applicable) Subscriber/Member ID # \_\_\_\_\_

**Labor and Industries Section:**

Is this a Labor and Industries Injury being covered by L&I? \_\_\_\_\_  
If so, Please provide L&I claim number \_\_\_\_\_ and card (if available) Date of Injury \_\_\_\_\_  
Claim Representative handling your claim \_\_\_\_\_ Number \_\_\_\_\_

Please check if we have permission to leave a detailed message regarding billing and/or health information at the following locations? Phone \_\_\_ Work \_\_\_ cell \_\_\_ email \_\_\_ all \_\_\_

**Insurance Billing:**

Your insurance plans co-payment must be paid at the time of your visit. We will be glad to bill you insurance for you. In order for us to bill your insurance, we need the above insurance filled out completely. If your insurance does not cover the particular service you receive, you will be responsible for payment of the services and will be billed directly. If you receive direct payment from the insurance company, it is your responsibility according to State regulation to use those funds to pay you account at this office.

**Need for Pre-Authorization:**

If you are required by you insurance plan to have a referral before your visit at this office, please notify our office staff. If this office does not receive the proper authorization for your services, you will be responsible for paying the amount due in full.

**Payment by check:**

A \$25.00 fee will be charged on all returned checks. If your check is returned, you will have 30 calendar days to bring your account current or you will be discharged as a patient of the clinic and sent to collection.

**Missed Appointments:**

It is important that you keep your scheduled appointments. If you cannot keep your appointment, a courtesy call to advise us would be appreciated. Therefore we can reschedule a needed appointment to fill your time slot.

**I hereby authorize release of my medical and other information containing information required for processing my insurance claim or to aid in the resolution of healthcare issues described in my chart in this office. I request payment of any and all medical insurance benefits to the party who accepts assignment of payment for those medical services.**

Signature of

Patient/Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**MICHAEL S EICKERMAN MD OF MONROE GENERAL SURGERY AND PUGET SOUND VEIN CENTER**  
**14841 179<sup>th</sup> AVE SE Suite 140 Monroe, WA 98272 360-794-1415**