



SOUND NATURAL MEDICINE

284 Central Way - Kirkland, WA 98033

Patient Information

Patient Name: _____ MI: _____ Last: _____
 Street Address: _____ Email: _____
 City: _____ State: _____ ZIP: _____
 SSN: _____ Gender: ()M ()F Home Ph: () _____
 Employer: _____ Work Ph: () _____
 Date of Birth / / Age: _____ Alt Ph: () _____

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: _____
 In emergency contact: _____ Phone: () _____
 Referred By: _____

PRIMARY INSURANCE

Insurance Company Name: _____ Phone: () _____
 Claims Address: _____ City, St, ZIP: _____
 Subscriber's Name: _____ Date of Birth / / SSN: _____
 Subscriber's Address: _____ City, St, ZIP: _____
 Relationship to you: ()Self ()Spouse ()Dependent ()Other
 I.D. # as shown on card: _____ Group # _____
 Employer of insured: _____ Phone: () _____

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? ()Y ()N Work related? ()Y ()N Auto accident? ()Y ()N State: _____
 Insurance Company Name: _____ Phone: () _____
 Claims Address: _____ City, St, ZIP: _____
 Subscriber's Name: _____ Date of Birth / / SSN: _____
 Subscriber's Address: _____ City, St, ZIP: _____
 Relationship to you: ()Self ()Spouse ()Dependent ()Other
 I.D. # as shown on card: _____ Group # _____
 Employer of insured: _____ Phone: () _____

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: _____

SEE REVERSE