CASCADE INTERNAL MEDICINE SPECIALISTS

Patient Registration Form

PATIENT INFORMATION (Please print Last , First, & Middle)	**Home Phone: ( )**
Patient Name:	**Work Phone: ( )**
Spouse Name:	**Email Address:**

Address:	**City:**	**State and Zip Code:**

Birth Date: / /	___ **Male** ___ **Female**	**Social Security Number:**	**Family Physician:**

Employer Name:	**Occupation:**
Employer Address, City & State:	

Insurance Company	**Subscriber's name**	**Subscriber's Address**	**Subscriber's Birth Date**
1.			/ /
2.			/ /

RESPONSIBLE PARTY (PARENT OR GUARDIAN)	**Home Phone: ( )**
Name (Last, First, Initial):	**Work Phone: ( )**
	E-mail Address:

Mailing Address:	**City:**	**State and Zip:**

Birth Date: / /	___ **Male** ___ **Female**	**Social Security Number:**	**Marital Status (please circle one):** **Married Single Other**

Employer Name:	**Employer Address, City & State:**

I GIVE PERMISSION FOR THE FOLLOWING INDIVIDUALS TO SEEK MEDICAL CARE FOR MY CHILD:

NAME	RELATIONSHIP TO CHILD	COMMENTS

OTHER FAMILY MEMBERS WHO ARE PATIENTS AT CASCADE INTERNAL MEDICINE SPECIALISTS

NAME	NAME	NAME

OTHER INFORMATION

Is This Your First Visit To Cascade Internal Medicine Specialists? Yes No

New Patients - How Did you Hear About Us? ☐ Family/Friend ☐ Physician Referral ☐ Provider Directory ☐ Advertisement (what source? __________________) ☐ Other ____

We appreciate your feedback. Comments?

____

EMERGENCY CONTACT INFORMATION

Name:	**Relationship:**	**Home Phone:** **Work Phone:** **Cell Phone:**
Address, City & State:		

Race: American Indian or Alaska Native ___
Asian ___ Native Hawaiian ___
Black or African American ___ White __
Hispanic ___ Other Race____
Unreported / Refused to Report ___

Ethnicity: Hispanic __
Non-Hispanic __
Refused to Report __

Language: English __ Spanish __
Russian __ Other ___

FINANCIAL AGREEMENT

I, the undersigned, ❑ have insurance coverage, ❑ do not have insurance coverage and authorize direct payment to Cascade Internal Medicine Specialists (CIMS). I acknowledge that I will be financially responsible for all charges, whether or not paid by my insurance. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. **There will be a $25.00 service charge on all returned checks.** In addition, I authorize CIMS to release information, as necessary, in order to facilitate treatment, payment or other healthcare operations.

SIGNATURE:____ **DATE** _ ____