RAINIERMEDICAL

Patient Demographic & Insurance Information Sheet

Name _____ Date of Birth_____

Mailing address: Street: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ May we leave detailed message? Yes No

Other Phone: _____ May we leave detailed message? Yes No

May we text appointment reminders? Yes No. May we send program texts? Yes No

Preferred Email address: (please print legibly) _____

Emergency contact name: _____Phone: _____

Relationship: _____ Primary care physician (PCP): _____

Date of last visit: _____ Date of last blood work and lab drawn? _____

Primary Insurance Information

Subscribers Name: _____Subscriber DOB: _____

Guarantor Date of Birth: _____

Guarantor Address: _____

Insurance Company: _____

Group Number: _____ Member ID_____

Secondary Insurance Information

Subscribers Name: _____Subscriber DOB: _____

Guarantor Date of Birth: _____

Guarantor Address: _____

Insurance Company: _____

Group Number: _____ Member ID_____

Assignment of Insurance Benefits

Please Read & Sign The Following:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

I directly assign all medical benefits to (Insert Provider Name here) and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize (Insert Provider Name here) to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this original shall be as valid as the original. Initial: _____

Permission to Contact:

"By signing below, you are authorizing us to call you at whatever phone numbers you provide, to include your home phone, work phone, and mobile phone, regarding outstanding balances and any other matters related to your treatment at our facility."

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth