Whidbey Island Internal Medicine 77 N Main St, Coupeville, WA 98239

PATIENT INFORMATION

Name:_____
Last First Middle
Mailing Address: _____
Street Address, City, State, Zip Code
Home Phone No: _____ Cell No: _____

Work No: _____ Date of Birth: _____Social Security Number: _____ - _____ - _____

☐Male ☐Female

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner ☐Dependent Child
Employer: _____

FAMILY INFORMATION

Check one: ☐Spouse of patient ☐Domestic Partner of patient ☐Parent of patient ☐Other: _____

Name: _____
Last First Middle
Mailing Address: _____
Street Address, City, State, Zip Code
Phone Number: _____ Date of Birth: _____

Employer: _____

EMERGENCY CONTACT

Name: _____Phone: _____Relationship to Patient: _____
Mailing Address: _____
Street Address, City, State, Zip Code

INSURANCE INFORMATION

Insurance Company #1: _____ Policy Holder: _____
(Have card available for receptionist to photocopy)

Insurance Company #2: _____ Policy Holder: _____
(Have card available for receptionist to photocopy)

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and clinic to release any information to process insurance claims. I also authorize my insurance claim to be paid directly to the clinic, unless otherwise specified.

Patient Signature: _____ Date: _____