SAN JUAN HEALTHCARE

689 Airport Center, Suite B Friday Harbor, WA 98250 (360) 378-1338

PATIENT INFORMATION: Please Print and Use Full Legal Names		
Last Name:	First Name:	Middle Initial:
Ethnicity/Race: Please Circle One Hispanic—American Indian—Asian—Black—Hawaiian—White—Other—Unknown--Declined		Language:
Current Address (Physical and Mailing Please):		
City:	State:	ZIP:
Home Phone:	Work Phone:	Cell:
Email:		
Birth Date:	Gender: M-—F	SSN#
Marital Status: S—-M—-D—-W—-N/A		
Spouse's Name:		
Custodial Parents Names:		
Phone#:		
Emergency Contact:	Phone:	Relation:
Employer:	Address:	Phone:
GUARANTOR (PERSON RESPONSIBLE FOR BILL):		
Last Name:		
First Name:	Middle Initial:	
Patient's Relationship to Guarantor:		
Current Address:		
Home Phone:	Work Phone:	Cell:
Employer:	Address:	Phone:
INSURED (PERSON WHO CARRIES INSURANCE FOR PATIENT):		
Last Name:		
First Name:	Middle Initial:	
Patient's Relationship to Insured:		
Birth Date:	Gender: M-—F	SSN#
Employer:	Address:	Phone:
PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST—THANK YOU!		
INSURANCE CARD COPY ATTACHED ❑		**PRIVATE PAYMENT ❑**
RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/RESPONSIBILITY FOR PAYMENT: I authorize my insurance benefits to be paid directly to my health care provider. I authorize the release of any information required for processing the insurance claim. I have also read the billing policy. I agree that I am financially responsible for any balance due.		
SIGNATURE:		**Date**
RELATIONSHIP TO PATIENT:		**Date**