PATIENT REGISTRATION FORM

Lake Washington Vascular, 1135 116th Ave NE, Suite 305, Bellevue, WA 98004 | Phone: (425)453-1772 | Fax: (425) 453-0603

Annual updates to this form ensure your information is current, supporting optimal care, efficient service, and compliance with health regulations. Please complete ALL sections. Thank you for your cooperation.

Patient Information

Patient's Name (Last, First, Middle) ______________________________

Address ______________________________

Social Security Number (Optional) ______________ **Date of Birth** ______________ **Sex** ☐ **M** ☐ **F**

Marital Status ______________ **Spouse's Name** ______________

Preferred Language ______________ **Will you need an interpreter?** ☐ **Y** ☐ **N**

Race ☐ American Indian or Alaska Native ☐ Hawaiian or Other Pacific Islander
☐ Asian ☐ White
☐ Black or African American ☐ Other ______________

Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other ______________

Patient Contact Information

Cell Phone ______________ Home Phone ______________ Email Address ______________

☐ *If you provide your email address you can enroll in our Patient Portal, portal benefits include ability to view your visit notes and lab reports, as well as send a brief non-urgent message to your provider's team. Please check the box if you wish to enroll in the Patient Portal.*

Automated Appointment Reminders: Our clinic provides automated appointment reminders through text or automated calls. These reminders are one-way communication and can't be used to reply back. For any inquiries, please contact us directly via our main number. You can change your preferred reminder method at any time.

Patient Contact Information

Please list the person you would like us to contact in the event of an emergency.

Name ______________ Phone Number ______________ Relationship to Patient ______________

Address ______________________________

Referring Provider

Name ______________ Phone Number ______________ Clinic/Hospital ______________

Address ______________________________

☐ **Please check here if you are self referred.**

Patient Insurance Information

Please document your insurance information below to declare which insurance is primary and secondary (if applicable). This is to ensure that we bill your insurance correctly. Please note that you will be responsible for any amount not covered by your insurance carrier.

Primary Insurance ______________ Policy Number ______________ Group Number ______________

Primary Subscriber Name ______________ Relationship to Patient ______________ Subscriber DOB ______________

Secondary Insurance ______________ Policy Number ______________ Group Number ______________

Secondary Subscriber Name ______________ Relationship to Patient ______________ Subscriber DOB ______________

☐ **Please check here if you do not have insurance coverage.**

Please ask for a PHI disclosure form if you would like us to add a family member or a provider to your care team. This allows a family member or provider to communicate with our office regarding your protected health information.

Please check this box if you wish to enroll in the ezAccess Patient Portal.

NOTE: By signing below, you acknowledge that all information contained on this form is true to the best of your knowledge.

Patient Signature ______________________________ Date ______________

Patient Representative's Signature ______________________________ Date ______________

Relationship to Patient

☐ Parent ☐ Legal Guardian* ☐ Medical Power of Attorney* ☐ Executor of Estate*

**Please attach any legal documentation if you are the Legal Guardian, Medical Power of Attorney, or Executor of Estate.*

PLEASE PROVIDE A COPY OF YOUR GOVERNMENT-ISSUED PHOTO ID