ZHI-PING KOLOUCH, LAc

6300 9TH AVE NE, #200 ~ SEATTLE, WA 98115 (206) 522-5646

PATIENT REGISTRATION

PLEASE FILL OUT COMPLETELY

Patient Name _____ MI: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zipcode: _____

Email: _____ Gender: ( )M ( )F Home ph: ( )

Employer: _____ Work ph: ( )

Date of Birth: / / Age: _____ Alt ph: ( )

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependant ( )Partnered ( )Other

( )Parent / ( )Guardian / ( )Spouse / ( )Partner: _____ Phone: ( )

Referred by: _____

In case of emergency contact: _____ Relationship: _____

Phone: ( )

PRIMARY INSURANCE

Insurance Company Name: _____ Phone: ( )

Claims Address: _____

City, State, Zip: _____

Subscriber's Name: _____ Date of Birth: / /

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

I.D. **# as shown on card**: _____ Group #: _____

Employer of insured: _____

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? ( )Y ( )N Work related? ( )Y ( )N Auto accident? ( )Y ( )N State:

Insurance Company Name: _____ Phone: ( )

Claims Address: _____

City, State, Zip: _____

Subscriber's Name: _____ Date of Birth: / /

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

I.D./ Claim **# as shown on card**: _____ Policy #: _____

Employer if applicable: _____ Effective / **Date of Injury**: / /

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assesed a fee of up to $50.00. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature _____ Date _____