Hudson's Bay Medical Group Registration Form

100 E 33rd Street, Suite 206, Vancouver, WA 98663
Ph: (360) 695-1334 Fax: (360) 992-1159

Doctor's Name: _____

Patient Information:

First Name_____ MI_____ Last Name_____
Mailing Address_____ City _____State _____Zip _____
Date of Birth_____Male_____Female_____SSN_____
Home Phone _____ Cell Phone _____
Driver's License_____ E-Mail Address: _____
Race/Ethnicity _____ Primary Language _____
Marital Status (***please circle one***): Single/ Married/ Divorced/ Widowed

Additional Information:

Spouse Name _____ Phone Number _____

Emergency Contact Name *(other than spouse)* _____
Phone Number_____ Relationship_____

Employer Information:
Employer/Company Name_____Occupation_____FT/PT
Work Phone Number_____Address_____

Insurance information:
Please note: the following information must be filled out in order to bill your insurance company properly.

Primary Insurance:
Plan Name_____Address_____
Policy Holders Name _____ Date of Birth _____
ID Number _____ Group Number_____
Relationship to Patient _____ Effective Date _____

Secondary Insurance:
Plan Name_____Address_____
Policy Holders Name _____ Date of Birth_____
ID Number _____ Group Number_____
Relationship to Patient _____ Effective Date _____

I certify the above information given by me is correct and true.

Patient Name (PRINT) _____ Date _____

Patient or Legal Representative Signature _____ Relationship _____

PHONE MESSAGES
It is our policy to leave brief messages regarding lab results, imaging results and appointment dates and times. We do not leave messages for abnormal results.

PLEASE INITIAL TO GIVE CONSENT: _____