



**Northwest  
Respiratory  
Associates**

PATIENT NAME Last:		First:	MI:	DATE:
Nick Name:		Birth Date:	SSN:	
Address:		City, State:		Zip Code:
PHONE Home:		Work:	Cell:	
Can we leave messages on home or cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No			E-Mail :	
Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced				Student: <input type="checkbox"/> FT <input type="checkbox"/> PT
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Preferred Language:		Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:			Vision/Communication Impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No	
CONTACT INFO 1 <input type="checkbox"/> Guarantor <input type="checkbox"/> Subscriber <input type="checkbox"/> Emergency			Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Last Name:		First Name:	Address:	
Home Phone:		Cell Phone:	Employer:	
CONTACT INFO 2 <input type="checkbox"/> Guarantor <input type="checkbox"/> Subscriber <input type="checkbox"/> Emergency			Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Last Name:		First Name:	Address:	
Home Phone:		Cell Phone:	Employer:	
PRIMARY INSURANCE Carrier:			Phone:	
Group #:		Member/Cert #		
Subscriber Name:		Subscriber Date of Birth:		
SECONDARY INSURANCE Carrier:			Phone:	
Group #:		Member/Cert #		
Subscriber Name:		Subscriber Date of Birth:		
<p><b>Release and Assignment:</b> I hereby authorize the physician and insurance carrier to release any information required for medical service claims and for my insurance benefits to be paid to the physician. I am responsible for any deductibles, co-pays, co-insurance, or remaining balance due.</p>				
<p><b>Patient Privacy Policy:</b> I have received and reviewed the Joint Notice of Privacy Practices of UW Medicine and Certain Other Providers.</p>				
<p><b>Disclosure of Medical Information:</b> I authorize the disclosure of my medical record to:</p>				

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_