

Washington
Homeopathic
Clinic

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Bellevue, WA 98004
(425) 881-8929
www.wchomeopathy.com

Michael Baker, ND, MS,

Ryan Robbins, ND

Patient Registration Form

Patient name _____ Birth date _____ Gender _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell _____ Work _____
Voicemail OK? Y N

Email Address _____

Marital status (required by insurance) _____ OR Parent or Guardian name(s) _____

Person responsible for charges if different from patient:

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Insurance Information

Primary Insurance _____

ID number with Alpha Prefix _____ Group number _____

Subscriber name _____ Subscriber birth date (required) _____

Emergency Contact Information

Name _____ Phone _____ Relationship to patient _____

How did you hear about us? _____

Health insurance is an agreement between you and your insurance company. You are responsible for contacting your insurance carrier regarding coverage for treatment. If the insurer requires a referral you must have this paperwork completed prior to the visit and we must receive a copy prior to treatment. Our office bills only insurers with whom we have a contract. For all others payment is required at time of service.

I have read the above and agree to assume responsibility for charges incurred from treatment at Washington Homeopathic Clinic. I authorize my insurance company to pay physicians at this clinic for services rendered.

Signature

Date