

UW Medicine
NORTHWEST HOSPITAL
& MEDICAL CENTER
MIDWIVES CLINIC

Registration Form

PATIENT NAME: _____ DATE: _____
Last: _____ First: _____ MI: _____

Name you like to be called _____

Maiden name _____

Marital Status Single Married Partnered Widowed Divorced Separated

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Social Security Number _____

Birthdate _____ Age _____ Primary Care Physician: _____

Employer _____

Work Phone () _____

Responsible Billing Party/Relationship to Patient Self Partner/Spouse Child Parent

Give address and phone number if different from above: _____

Spouse or Partner's Name / Parent's Name (if patient is a minor) _____

Spouse, Partner or Parent's Phone () _____

Whom shall we call in an emergency? *(Please give name, address, area code and phone number.)* _____

Relationship to you: _____

Reason for visit _____

Primary Medical Insurance Carrier: _____ Member #: _____

Subscriber Name & DOB: _____ Group #: _____

Medicare Number: _____

Secondary Medical Insurance Carrier: _____ Member #: _____

Subscriber Name & DOB: _____ Group #: _____

I have no insurance. I agree to pay for services provided to me by the Midwives Clinic.

Signature: _____ **Date:** _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the Midwives Clinic. I am financially responsible for the balance due. I also authorize the Midwives Clinic or insurance company to release any information required for this claim.

Signature: _____ **Date:** _____

I acknowledge receipt of UW Medicine Northwest Hospital & Medical Center's Privacy Practices.

Signature: _____ **Date:** _____

How did you hear about the Midwives Clinic?
Referred by Dr. _____ Other: _____

Thank you! Our office continues to grow due to your referrals. We are pleased to care for your friends and family.