RUNSEATTLEPT

Questions about how to complete this form?
Call 206-465-5650

erin@runseattlept.com
www.runseattlept.com

Return completed form to:
106 Lakeside Ave,
Seattle, WA 98122

Patient Registration

FIRST NAME	MIDDLE NAME	LAST NAME
ADDRESS		
CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL
GENDER		BIRTH DATE	

MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other

Emergency Contact Information

EMERGENCY CONTACT	PHONE NUMBER	RELATIONSHIP

Current Employment / School Information

EMPLOYER / SCHOOL	EMPLOYER / SCHOOL ADDRESS

Physician Information

REFERRING PHYSICIAN	PHONE	ADDRESS

If you would like to send copies of correspondence to your primary care physician, please complete:

PRIMARY CARE PHYSICIAN	PHONE	ADDRESS

Insurance Information

WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE

PRIMARY INSURANCE COMPANY	CUSTOMER SERVICE PHONE #
NAME OF POLICY HOLDER	POLICY HOLDER DATE OF BIRTH
POLICY HOLDER EMPLOYER:	RELATIONSHIP
ID #	GROUP #
SECONDARY INSURANCE COMPANY	CUSTOMER SERVICE PHONE #
NAME OF POLICY HOLDER	POLICY HOLDER DATE OF BIRTH
POLICY HOLDER EMPLOYER:	RELATIONSHIP
ID #	GROUP #

Auto / 3rd Party Auto Information

IS THIS AN AUTO ACCIDENT? ☐ Yes ☐ No		DATE OF ACCIDENT	
INSURANCE COMPANY		PHONE	INSURANCE ADDRESS
CLAIM NUMBER	CLAIMS ADJUSTER		CLAIMS ADJUSTER PHONE
ATTORNEY NAME		ATTORNEY PHONE	

Worker's Compensation

DID YOUR INJURY OCCUR AT WORK? ☐ Yes ☐ No		DATE OF INJURY	JOB TITLE	EMPLOYER AT TIME OF INJURY
INSURANCE COMPANY		PHONE	INSURANCE ADDRESS	
CLAIM NUMBER	CLAIMS ADJUSTER		CLAIMS ADJUSTER PHONE	
ATTORNEY NAME		ATTORNEY PHONE		

Please sign to verify the above information is accurate

PATIENT NAME	SIGNATURE
RESPONSIBLE PARTY (IF NOT THE PATIENT)	
DATE	