Patient Information Form

green lake natural medicine
5413 Meridian Ave. N. Suite A, Seattle, WA 98103
Tel (206) 550-7539 • Fax (206) 462-4320

Last Name:___________________________ First Name:__________________________ Middle Name:________________

Preferred Name: __________________________________ SS#: _________ - _________ - _____________

Date of Birth (required): _______ / _______ / ____________

Gender at birth: _____________________ How do you identify? ___________________

Preferred Pronoun(s): ________________________

Address: ____ Unit #: ___________

City: ______________________ State: __________ ZIP: __________________

Other name(s) that records may be kept under:

____

PHONE:

1. Home/Work/Cell (______) ____________________ 2. Home/Work/Cell (_____) _________________________

** Confidential voicemails OK? Yes /No ** Confidential voicemails OK? Yes/No

Email: ____

Emergency Contact:

Name: ____ Phone: _____________________________
Relationship: ____________________

Are you currently employed? Yes/No

Employee/Address:

____

____

INSURANCE INFORMATION

Primary Insurance: __________________ Policy #: ____________________________

Group #: _______________________

Subscriber/Relationship_________________________________ Date of Birth (required): _____ / _____ / ______

Secondary Insurance: _______________ Policy #: ___________________________

Group #: _______________________

Subscriber/Relationship__________________________________ Date of Birth (required): _____ / _____ / ______

Please check below if applicable:

Auto Accident/Workers Compensation

Date of accident or injury: _________________________

Claim #: ____________________________

PARENT/GUARDIAN INFORMATION

Mother's Name (minors only):

____

Legal Guardian? Yes /No Date of Birth (required): ______ / ______ / _______

Father's Name (minors only):

____

Legal Guardian? Yes/No Date of Birth (required): ______ / ______ / _______

Other Legal Guardian Name:

____

Relationship to Patient: _______________________________ Date of Birth (required): _____ / _____ / ______

SIGNATURE

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

Patient Signature (18 and older): ____ Date _____ / _____ / _____

Parent/Guardian Signature: ____ Date _____ / _____ / _____

DEMOGRAPHIC DATA COLLECTION

Green Lake Natural Medicine is committed to providing quality care for all patients. We are asking you to provide your marital status; your racial and ethnic background; the language you prefer to use when speaking with your doctor; and whether you are or were military. Your answers are both voluntary and private. Thank you for your cooperation.

What is your marital status? Please circle one:

Single Married Significant Other Widowed

Do you consider yourself Hispanic or Latino? Please circle one:

I AM Hispanic or Latino I am NOT Hispanic or Latino I don't know Decline to answer

Which category best describes your race? You may circle one or more:

White or Caucasian Black or African American Asian Native American

Alaskan Native Native Hawaiian or other Pacific Islander Other race _____________

I don't know Decline to answer

What is your preferred language when speaking with your doctor?

English: Yes/No Other (please specify): ____

Are you Active military or veteran? Please circle one:

Yes No Decline to answer

How did you hear about Green Lake Natural Medicine? Please circle all that apply:

Friend/patient Event/Health Fair Physician/Specialist

External Referral Current Patient Walk by

Website Social Media Yelp

Google Other (please specify): ______________