PATIENT INFO	ORMATION														
Last Name			Fi	First Name				Middle Name							
Social Security Number Gender			er	Date of Birth			Name y	ame you preferred to be called/Alias							
Street Address		1				City				S	tate		Zip		
Home Phone	W	/ork Ph	ione		Cell Ph	one		Emai		!					
Marital Status Previous/Maiden Name					Written Language Spoken L					en La	anguag	je			
Interpreter Needed?				VA Status				Race/Ethnicity (optional)							
Primary Care Pro	ovider (Name	and Ph	hone)		E	nployer Na	me								
Emergency Cont	act	Re	lation		Home F	Phone	Work Phon			one			Cell Phone		
Legal Next of Kin (if different) Relation			lation		Home F	hone	Work	Work Phone			C	Cell Phone			
RESPONSIBL	E PARTY IN	IFORM	IATIO	N (if diffe	rent fro	om patien	t)								
Last Name				First Nar	ne				MI	Ali	as or	Maide	n Na	ne	
Social Security N	lumber Ge	ender		Date of E	Birth				Relatio	onshi	p to tl	he Pati	ent		
Street Address (i	if different fror	m abov	/e)	1			City				State		Zi	р	
Home Phone Work Phone			ione	ne				Cell Phone							
Employer Name				Occupation				Status							
PRIMARY INS	URANCE														
			Group Nu	p Number				Subscriber ID Number Copay							
Subscriber's Name Socia			Social Se	I Security Number			Da	Date of Birth Relationship to Patient				Patient			
Subscriber's Employer Name				Subscriber's Home Phone				Subscriber's Work Phone							
SECONDARY	INSURANC	Ε		1											
Insurance Company Name Group N			Group Nu	lumber			Sı	Subscriber ID Number Copay							
Subscriber's Name Social S			Social Se	Security Number			Da	Date of Birth Relationship to Patient							
Subscriber's Employer Name				Subscriber's Home Phone				Subscriber's Work Phone							

New Patient Registration Information

UW Medicine Harborview Medical Center – University of Washington Medical Center UW Medicine Primary Care – Valley Medical Center – UW Physicians NEW PATIENT REGISTRATION INFORMATION Page 1 of 2

DO NOT SCAN OR UPLOAD TO THE MEDICAL RECORD

DO NOT LABEL OR SCAN

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Is This Visit Related to Work Injury or Motor Vehicle Accident? If "yes", please complete the below.

□ Work Related Injury

Worker's Comp (Includes Labor & Industries)

Employer:				Date of Injury:		
Body Part Injured and Description:				Claim Number:		
Adjuster/Claims Manager Name:			Phor	ne Number:		
Insurance Name:		Address:				
City:	State/2	Zip:		L & I Claim Completed?	Yes	No

□ Motor Vehicle Accident (PIP) Insurance

Personal Injury Protection Insurance (Third Party/Motor Vehicle)

Date of Injury:	Body Part Injured and Description:
Claim Number:	Adjuster/Claims Manager Name:
Adjuster Phone Number:	Insurance Name:
Insurance Address:	
City:	State/Zip:

□ Attorney Billing

Attorney Information (Add'I Types/Special Physician Svcs)

Attorney Name:	Law Firm Name:
Billing Address:	
City:	State / Zip:
Fax:	Date of Injury:
Body Part Injured and Description:	

DO NOT LABEL OR SCAN	UW Medicine Harborview Medical Center – University of Washington Medical Center UW Medicine Primary Care – Valley Medical Center – UW Physicians NEW PATIENT REGISTRATION INFORMATION Page 2 of 2
	DO NOT SCAN OR UPLOAD TO THE MEDICAL RECORD

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