

Pre-Exam Patient Information Form *Please complete and bring with you to your appointment*

Date of Exam _____
Name _____ Social Security # _____
Address _____
City _____
State _____ Zip _____
Home Phone _____ Work Phone _____
Date of Birth _____ Referring MD _____

Primary Insurance *We accept Medicare assignment. We will also bill other insurance carriers.
Managed Care / HMO Insurance requires pre-authorization!*

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Regence Blue Shield | <input type="checkbox"/> Medicare | <input type="checkbox"/> Premera Blue Cross |
| <input type="checkbox"/> DSHS | <input type="checkbox"/> Group Health | <input type="checkbox"/> Pacificare |
| <input type="checkbox"/> Railroad/Medicare | <input type="checkbox"/> L&I | <input type="checkbox"/> Pac Med USFHP |
| <input type="checkbox"/> Health Plus | <input type="checkbox"/> Uniform Med | <input type="checkbox"/> Secure Horizon |
| | | <input type="checkbox"/> Other |
| | | <input type="checkbox"/> None |

SS# / ID# / L&I Claim# (& date of injury) _____
Group Name/Number _____
Subscriber Name _____
Subscriber's Employer _____
Relation to Subscriber: Self Spouse Dependent

If you checked other, please complete the following:
Insurance Name: _____
Insurance Address: _____
Insurance Phone: _____

Please bring your insurance card with you. We will need to make a copy.

Secondary Insurance

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Regence Blue Shield | <input type="checkbox"/> Uniform Med | <input type="checkbox"/> Premera Blue Cross |
| <input type="checkbox"/> Sterling | <input type="checkbox"/> AARP | <input type="checkbox"/> DSHS |
| | | <input type="checkbox"/> Other |
| | | <input type="checkbox"/> None |

SS# / ID# / L&I Claim# (& date of injury) _____
Group Name/Number _____
Subscriber Name _____
Subscriber's Employer _____
Relation to Subscriber: Self Spouse Dependent

If you checked other, please complete the following:
Insurance Name: _____
Insurance Address: _____
Insurance Phone: _____