North Olympic Healthcare Network
240 West Front Street | Suite A
Port Angeles, WA 98362-2609
(360) 452-7891 P | (360) 452-8087 F

# NEW PATIENT REGISTRATION - ADULT

## PATIENT INFORMATION

First Name ______________________________________________________

Last Name ______________________________________________________

Identifying Gender Male ☐ Female ☐ Social Security # ____________________________

Date of Birth _______________ Contact Phone # ______________________

Address _________________________________________________________

City _________________________ State _______ Zip ________________

Emergency Contact Name ________________________________________________

Contact Phone # _______________________ Relationship ______________________

## FEES AND BILLING

No patient will be denied service due to inability to pay. We offer a Sliding Fee Discount program which can provide discount fees for certain services. To see if you qualify please complete the information below.

**Gross Monthly Household Income** $ ____________________

**Number of Family Members in Your Household** ________

I decline to see if I qualify for Sliding Fee Discount ☐

**PATIENT NAME** ________________________________ **DATE OF BIRTH** ____________

**ASSISTANCE**

Does the patient need a language interpreter for appointments? ☐ Yes ☐ No

Does the patient need a sign language interpreter for appointments? ☐ Yes ☐ No

Does the patient need help with transportation assistance to appointments? ☐ Yes ☐ No

**INSURANCE INFORMATION**

Do you have health insurance? Yes ☐ No ☐
If no, would you like information on signing up for health insurance? Yes ☐ No☐

Insurance Name ____________________________________________

Policy Number __________________________Group Number ___________________

Subscriber Name _________________________ Subscriber Date of Birth ___________

Subscriber relationship to patient __________________________________________

**Do you have a secondary insurance?** Yes ☐ No ☐

Insurance Name ____________________________________________

Policy Number __________________________Group Number ___________________

Subscriber Name __________________________Subscriber Date of Birth ___________

Subscriber relationship to patient __________________________________________