Eastside Family Health Center, P.S.

Frank F. Marinkovich M.D. * Rita A. Marinkovich, A.R.N.P **Office: (425) 899-2525**

PATIENT INFORMATION

(Circle one) Mr. / Mrs. / Ms. / Miss	(Circle one) Single / Married / Widowed / Separated / Divorced
Patient's Name	Email Address:
Patient's Mailing Address:	City, State, Zip
Home Phone:	Cell Phone:
Age: Birthdate: Male / Female	Social Security #:

Employer: Occupation: Work Phone:

Referred by: Previous Physician: Send Report? Yes / No

EMERGENCY CONTACT

Emergency Contact:	Relationship:
Home Phone: Cell Phone: Work Phone:	
Emergency Contact's Mailing Address:	City, State, Zip

PERSON RESPONSIBLE FOR BILL

(Circle one) Self / Parent / Attorney / Other If other, please explain:

Name:	Phone:	Fax:
Patient's Mailing Address:	City, State, Zip	

IF ACCIDENT, COMPLETE BELOW

Date of Accident / Injury: _____ ☐ Adjuster ☐ Agent

☐ Labor & Industry (L&I) ☐ Self Insured Phone: _____ Fax: _____

☐ Motor Vehicle ☐ Other: _____ Name: _____

Policy #: _____ Address: _____

Claim #: _____ Date Opened: _____ City, State, Zip: _____

Reopened: _____ Closed: _____

ASSIGNMENT OF BENEFITS

I hereby assign to Eastside Family Health Center any insurance or other third-party benefits available for health care services provided to me. I understand that Eastside Family Health Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Eastside Family Health Center, I agree to forward to Eastside Family Health Center all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

SIGNATURE: _____ **DATE:**_____

PARENT / GUARDIAN SIGNATURE _____ **DATE:**_____
(if patient is under 18 years of age)