

# CASCADE INTERNAL MEDICINE SPECIALISTS

## Patient Registration Form

|   |  |                                 |   |
|---|--|---------------------------------|---|
| <b>PATIENT INFORMATION (Please print Last, First, &amp; Middle)</b> |  | Home Phone: (    )              |   |
| Patient Name:   |  | Work Phone: (    )              |   |
| Spouse Name:  |  | Email Address:                  |   |
| Address:  |  | City:                           | State and Zip Code:   |
| Birth Date:<br>/ /  | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Social Security Number:         | Family Physician:   |
| Employer Name:  |  | Occupation:                     |   |
| Employer Address, City & State:                                     |  |                                 |   |
| Insurance Company   | Subscriber's name  | Subscriber's Address            | Subscriber's Birth Date<br>/ /                                    |
| 1.  |  |                                 | / /   |
| 2.  |  |                                 | / /   |
| <b>RESPONSIBLE PARTY (PARENT OR GUARDIAN)</b>                       |  | Home Phone: (    )              |   |
| Name (Last, First, Initial):  |  | Work Phone: (    )              |   |
|   |  | E-mail Address:                 |   |
| Mailing Address:  |  | City:                           | State and Zip:  |
| Birth Date:<br>/ /  | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Social Security Number:         | Marital Status (please circle one):<br>Married    Single    Other |
| Employer Name:  |  | Employer Address, City & State: |   |

**I GIVE PERMISSION FOR THE FOLLOWING INDIVIDUALS TO SEEK MEDICAL CARE FOR MY CHILD:**

| NAME | RELATIONSHIP TO CHILD | COMMENTS |
|------|-----------------------|----------|
|      |                       |          |

**OTHER FAMILY MEMBERS WHO ARE PATIENTS AT CASCADE INTERNAL MEDICINE SPECIALISTS**

| NAME | NAME | NAME |
|------|------|------|
|      |      |      |

**OTHER INFORMATION**

Is This Your First Visit To Cascade Internal Medicine Specialists?    Yes    No

New Patients - How Did you Hear About Us?     Family/Friend     Physician Referral     Provider Directory     Advertisement (what source? \_\_\_\_\_)     Other \_\_\_\_\_

**We appreciate your feedback. Comments?**  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

|   |  |             |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
|---|--|-------------|---|--------------------------------|-------------------------------|------------------|---|-----------------------|-----------------------------|--|------------------------------------|--|--|-----------------------|
| Name:   | Relationship:                            | Home Phone: |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
| Address, City & State:  |  | Work Phone: |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
|   |  | Cell Phone: |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
| <table style="width: 100%;"> <tr> <td><b>Race:</b> American Indian or Alaska Native ___</td> <td><b>Ethnicity:</b> Hispanic ___</td> </tr> <tr> <td>Asian ___ Native Hawaiian ___</td> <td>Non-Hispanic ___</td> </tr> <tr> <td>Black or African American ___ White ___</td> <td>Refused to Report ___</td> </tr> <tr> <td>Hispanic ___ Other Race ___</td> <td></td> </tr> <tr> <td>Unreported / Refused to Report ___</td> <td><b>Language:</b> English ___ Spanish ___</td> </tr> <tr> <td></td> <td>Russian ___ Other ___</td> </tr> </table> |  |             | <b>Race:</b> American Indian or Alaska Native ___ | <b>Ethnicity:</b> Hispanic ___ | Asian ___ Native Hawaiian ___ | Non-Hispanic ___ | Black or African American ___ White ___ | Refused to Report ___ | Hispanic ___ Other Race ___ |  | Unreported / Refused to Report ___ | <b>Language:</b> English ___ Spanish ___ |  | Russian ___ Other ___ |
| <b>Race:</b> American Indian or Alaska Native ___   | <b>Ethnicity:</b> Hispanic ___           |             |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
| Asian ___ Native Hawaiian ___   | Non-Hispanic ___                         |             |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
| Black or African American ___ White ___   | Refused to Report ___                    |             |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
| Hispanic ___ Other Race ___   |  |             |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
| Unreported / Refused to Report ___  | <b>Language:</b> English ___ Spanish ___ |             |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |
|   | Russian ___ Other ___                    |             |   |                                |                               |                  |   |                       |                             |  |                                    |  |  |                       |

**FINANCIAL AGREEMENT**

I, the undersigned,  have insurance coverage,  do not have insurance coverage and authorize direct payment to Cascade Internal Medicine Specialists (CIMS). I acknowledge that I will be financially responsible for all charges, whether or not paid by my insurance. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. **There will be a \$15.00 service charge on all returned checks.** In addition, I authorize CIMS to release information, as necessary, in order to facilitate treatment, payment or other healthcare operations.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_