WILLIAM A. PORTUESE, M.D.

PATIENT INFORMATION (PLEASE PRINT)

NAME _____ DATE _____
FIRST MIDDLE LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE ( ) _____ ( ) _____ ( ) _____
HOME CELLULAR WORK

BIRTHDATE ___/___/___ GENDER: ☐ M ☐ F

OCCUPATION _____ EMPLOYER _____

EMAIL _____@_____

YOUR PRIMARY CARE PROVIDER _____

WHO CAN WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

INSURANCE INFORMATION

INSURANCE _____ 2ND INSURANCE _____

SUBSCRIBER NAME _____ SUBSCRIBER NAME _____

BIRTH DATE _____ BIRTH DATE _____

ID# _____ ID# _____

GROUP# _____ GROUP# _____

PT RELATION TO SUBSCRIBER _____ PT RELATION TO SUBSCRIBER _____

PLEASE COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE

RELATIONSHIP TO PATIENT _____

GUARANTOR/PERSON RESPONSIBLE FOR PAYMENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE ( ) _____ CELLULAR ( ) _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

IN CASE OF EMERGENCY CONTACT INFORMATION

FRIEND OR RELATIVE WHO IS ***NOT*** LIVING AT SAME ADDRESS AS PATIENT TO BE NOTIFIED

CONTACT NAME _____ RELATIONSHIP TO PATIENT _____

HOME ( ) _____ CELLULAR ( ) _____

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR MEDICAL CLAIMS. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE

PATIENT SIGNATURE _____

GUARANTOR'S SIGNATURE _____

1101 MADISON ST #1280, SEATTLE WA 98104 (P) 206.624.6200 (F) 206.624.0244