710 NW Juniper St., Suite 100
Issaquah, WA 98027
Tel: 425.369.4702 | Fax: 425.369.4707
www.eastsideot.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:	DOB:	Sex: ◯ M ◯ F

PARENT INFORMATION

Parent/Legal Guardian:			
Address:	City:	State:	Zip Code:
Employer:			

Home Phone:	Cell Phone:	Work Phone:

Email:	Preferred method of contact: ◯home ◯cell ◯work ◯email

Other Parent/Legal Guardian:			
Address (if different than above):	City:	State:	Zip Code:
Employer:			

Home Phone:	Cell Phone:	Work Phone:

Email:	Preferred method of contact: ◯home ◯cell ◯work ◯email

PROVIDER INFORMATION

Physician/Provider Name:	Phone #:
Group/Clinic Name:	Location:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for the balance. I understand that any unpaid balance over 60 days is subject to a 1% finance charge and possible collection action. I also authorize Eastside Occupational Therapy or my insurance company to release any information required to process my claims.

Parent/Guardian Signature: ____ ***Date:*** _________________________