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

Name:		**Date of Birth:**	
Address:	**City:**	**State:**	**Zip Code:**
Employer:			
Home Phone:	**Cell Phone:**	**Work Phone:**	
Email:		**Preferred method of contact:** ◯**home** ◯**cell** ◯**work** ◯**email**	

Emergency Contact:			
Address (if different than above):	**City:**	**State:**	**Zip Code:**
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.

Signature: _____ ***Date:*** _____