☐ Marco Vespignani, N.D.
☐ Laurie Mischley, N.D.
☐ Chris Holder, N.D. Lac
☐ Jason Allen N.D.
☐ Melissa McCarty N.D.

Patient Registration

Seattle Integrative Medicine

5322 Roosevelt Way NE, Seattle, WA 98105

(206) 525-8012

Please fill out completely

Patient Name: MI: Last:

Email: ☐ I would like to use online scheduling/receive information via email

Street Address:

City: State: Zip:

SSN: Gender: Female Home ph: ( )

Employer: Work ph: ( )

Date of Birth: / / Age: Alt ph: ( )

Employment: ◯ Employed ◯ F/T Student ◯ P/T Student ◯ Retired ◯ Other

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Dependant ◯ Partnered ◯ Other

Referred by:

In case of emergency contact: Relationship:

Phone: ( )

PRIMARY INSURANCE

Insurance Company Name: Phone: ( )

Claims Address:

City, State, Zip:

Subscriber's Name: Date of Birth: / /

Relationship to you: ◯ Self ◯ Spouse ◯ Dependant ◯ Other

I.D. # **as shown on card**: Group #:

Employer of insured:

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? No Work related? No Auto accident? No State:_____

Insurance Company Name: Phone: ( )

Claims Address:

City, State, Zip:

Subscriber's Name: Date of Birth: / /

Relationship to you: ◯ Self ◯ Spouse ◯ Dependant ◯ Other

I.D./ Claim # **as shown on card**: Policy #:

Employer if applicable: Effective / Injury Date: / /

☐ *I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.*

Signature _____ Date _____