

**THE STELLA CENTER**  
509 Olive Way, Suite 1430  
Seattle, WA 98101

**PATIENT REGISTRATION INFORMATION**

Date: \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Last Name First Name Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Sex  M  F  Minor  Single  Married  Long Term Partner  Divorced  Widowed  Separated

**I hereby acknowledge that I have received a copy of the *Notice of Privacy Practices* form:** \_\_\_\_\_ (Please Print Initials)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Primary Care Physician/Primary Care Facility: \_\_\_\_\_

How did you hear about us?  Newspaper: \_\_\_\_\_  Internet: \_\_\_\_\_

Physician: \_\_\_\_\_  Seminar: \_\_\_\_\_

Yellow Pages  Friend or Relative: \_\_\_\_\_  Other: \_\_\_\_\_

May we contact you to remind you about upcoming or missed appointments? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please provide your preferred contact phone number \_\_\_\_\_

**BILLING INFORMATION**

Person Responsible for Account: \_\_\_\_\_  
(if other than patient) Last Name First Name Initial

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Do you have Medicare?  Yes  No Medicare ID#: \_\_\_\_\_

Are you seeking care in relation to an accident?  Yes  No At Work?  Yes  No

Name of Primary Insurance Company: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I hereby authorize payment directly to Edmonds Facial Plastic Surgery for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_