

Minor and James Medical, PLLC

First Hill Medical Building
Seattle, WA 98104
(206) 386-9500

PATIENT INFORMATION						
NAME (Last, First, Middle)			MRN	SSN #	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE, ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		REFERRING PHYSICIAN	CITY, STATE, ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)		
ADDRESS				ADDRESS		
CITY, STATE, ZIP				CITY, STATE, ZIP		
WORK PHONE				WORK PHONE		

RESPONSIBLE PARTY INFORMATION (if Different than above)						
NAME (Last, First, Middle)			SSN #	BIRTHDATE	SEX	
LOCAL ADDRESS			CITY, STATE, ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE, ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY AMT.	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY AMT.	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN _____

DATE _____