WESTERN MEDICINE, INC. FAMILY PHYSICIANS

___Jacob Dean, M.D. ___Alexandra Tran, PA-C

___Trent Nourse, PA-C ___Victoria Hase, PA-C ___Jennifer Dyer, NP-C

Patient Information - Please Print			Date
Patient Name	Birth Date	Age	SS#
Street Address	Home Phone #:		
City/State/Zip Code	Sex: Male /Female		Marital Status
Race: *(circle one)* African American or Black American Indian	Preferred Language :		
Asian Native Hawaiian White	Ethnic Group: Hispanic or Latino / Not Hispanic or Latino		
Employed by:	Work Phone #:		Cell #
Spouse's Name (if applicable)	**E-mail address :**		
Guarantor Information (Person responsible for payment)			
Name	Birth Date	Age	SS#
Street Address	Home Phone #:		
City/State/Zip Code	Sex: Male /Female		Martial Status
Employed by:	Work Phone #:		
ALTERNATE CONTACT PERSON: In the event we are unable to contact you at the above address or phone			
Name	Phone #:		Relationship
Primary Insurance (Policy Holder Information) **Please give your card(s) to the receptionist to copy**			
Insurance Coverage _____Yes _____No	If no insurance, method of payment		
Insurance Company	Group #	Policy #	
Insured Name	Birth Date	SS#	
Secondary Insurance (Policy Holder Information)			
Insurance Company	Group #	Policy #	
Insured Name	Birth Date		
Name of your Pharmacy, Location and phone # (if known)			

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED.

Payment Policy: I understand that if Western Medicine,LLC, is a participating provider with my insurance, and if I'm responsible for any deductible or co-payment, I am required to pay at time of service. If, however, Western Medicine, Inc. is not a participating provider with my insurance, I understand that I am expected to pay my bill IN FULL at the time of service. If I am unable to do so, arrangements must be made in advance and with the provider's approval, a payment plan may be arranged. Out of courtesy, the physician will submit a claim to my insurance company for me. I agree to assign and authorize payment made directly to the physician of all insurance benefits. I understand it is mandatory to notify my health care provider of any other party who may be responsible for paying for my treatment.

Signature	**Date**

REGISTRATION UPDATES

Date: _____ ____ Reviewed ____ No Changes Signature: _____

Date: _____ ____ Reviewed ____ No Changes Signature: _____