SARAH E. McMILLAN, MD

PHONE: 425-821-6000 FAX: 425-820-6288

Patient Name_____
First Middle Last

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____Work Phone_____

Email_____ Any restrictions when contacting you?_____

Age_____ Birth date_____ SS#_____ Gender: Female_____ Male:_____ Marital Status:_____

Spouse Name_____ Contact Number_____

Patient Employer_____ Occupation_____

Emergency Contact_____ Phone number_____

Relationship to patient_____

How did you hear about Dr McMillan? _____

INSURANCE INFORMATION

Primary:
Ins. Co._____
Address:_____

ID#_____ Group#_____ Co-pay_____

Insured Name_____ DOB_____SS#_____

Secondary:
Ins. Co._____Address:_____

ID#_____ Group#_____ Co-pay_____

Insured Name_____ DOB_____SS#_____

L&I /MVA/Other
Claim**#**_____ Date of Injury_____ Attorney_____ Phone #_____

I hereby authorize payment of any surgical and/or medical benefits directly to the physician for services. I also agree to pay all charges that exceed or are not covered by insurance and authorize release of information to the insurance company. I also authorize the physician to disclose information to those individuals qualified for the purpose of medical quality assurance and peer review.

Signature:_____ Date:_____