BOOTH GARDNER PARKINSON'S CARE CENTER

NEW PATIENT REGISTRATION FORM

Return to us via fax (425.899.3114) or by mail to: Booth Gardner Parkinson's Care Center
12039 128th St NE, 3rd Floor
Kirkland, WA 98034

LAST NAME:			FIRST NAME:		MI:
PHYSICAL ADDRESS:			APT. #:		
CITY:	ST:	ZIP:	HOME PHONE:		
MAILING ADDRESS (INCLUDE CITY, STATE, ZIP:					

DATE OF BIRTH:	SSN:
ETHNICITY:	RELIGION:
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other:	

Family Doctor:	
Referring MD:	
Do you have a Living Will or an ACD?	❒ Yes ❒ No
Are you able to walk on your own?	❒ Yes ❒ No

Work Status: (circle one) ❒ Full Time ❒ Part Time ❒ Retired ❒ Unemployed ❒ Self Employed		
Employer:	Occupation:	
Address:	Work Phone:	
City:	St::	Zip:

Emergency Contact Information:
Last Name ______________________________ First Name ____________________
Relationship to Emergency Contact ____
Phone Number__________________________ Second Phone: ______________________

(Continued)

Insurance Information (If possible, please attach a copy of the front and back of your card)

Subscriber Last Name:		First Name:	
Address:		Home Phone:	
City:		St::	Zip:
Birthdate:	SSN:		

Employer:	Occupation:	
Address:	Work Phone:	
City:	St::	Zip:

Insurance Co. Name:		
Insurance Co. Address:	Customer Service Phone:	
City:	St::	Zip:
Policy:	Group #:	

Secondary Insurance Information

Subscriber Last Name:		First Name:	
Address:		Home Phone:	
City:		St::	Zip:
Birthdate:	SSN:		

Employer:	Occupation:	
Address:	Work Phone:	
City:	St::	Zip:

Insurance Co. Name:		
Insurance Co. Address:	Customer Service Phone:	
City:	St::	Zip:
Policy:	Group #:	

Comments/Notes:____

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