

Alina Bouza, MD, PLLC
11416 Slater Ave NE #202 C
Kirkland, WA 98033
(206) 393-7111

REGISTRATION FORM

Today's Date: ___/___/___

Name (first, middle, last): _____ Age: ___ Sex: ___
Address: _____ Social Security #: _____
City, State, Zip: _____ Date of Birth: _____
Home Phone: _____ May I call this number? Y N Leave a message? Y N
Cell Phone: _____ May I call this number? Y N Leave a message? Y N
Email: _____ May I email appt reminders? Y N
Person Responsible for Bill: _____ Relationship: _____
Address: _____ Phone: _____

EMPLOYER INFORMATION

Employer: _____ Occupation: _____
Address: _____
Work Phone: _____ May I call this number? Y N Leave a message? Y N

INSURANCE INFORMATION

Name of insured: _____ Social Security #: _____ DOB: _____
Primary Insurance
Company: _____
Address: _____ Phone: _____
Subscriber/ID #: _____ Group #: _____
Name of Insured: _____ Social Security #: _____ DOB: _____
Secondary Insurance
Company: _____
Address: _____ Phone: _____
Subscriber/ID #: _____ Group #: _____

MEDICAL & REFERRAL INFORMATION

Name of PCP: _____ Phone: _____
Name of Therapist/Counselor: _____ Phone: _____

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By whom were you referred? _____ Relationship: _____

HOUSEHOLD INFORMATION

Spouse/Partner Name: _____

Employer: _____ Work Phone: _____

Others in Home: _____ Gender: _____ Age: _____ Relationship: _____

EMERGENCY CONTACT

If Emergency, contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Legal next of kin: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

I certify that the above information is true and correct.

Signature

Date