Registration

Que Areste N. D., 1605 12th Ave., Suite 16, Seattle, WA 98122
(206) 328-2926

Please Print		Date
Patient Name (Last, First Middle)		Previous Name
Street Address		City, State, Zip Code
Home Telephone ( )	Mobil Phone ( )	Fax ( )

Email address:_____ Web Address:_____

Date of birth:	Sex: Male Female	Employer
Social Security Number _____/____/_____	Marital Status: Single Married Widowed Divorced Other	Employer Address
		Work Phone (_____) _____

Spouse or Significant Other
Name (Last, Middle, First)_____ Relationship_____
Employer_____

Address (If different than patient)
Street:_____
City, State, Zip_____

Home Phone (_____) _____
Work Phone (_____) _____

Emergency Contact
Name (Person not living with you)_____

Relationship:_____
Telephone:_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Que Areste N. D., Que Areste on my behalf for unpaid services rendered by Que Areste, N.D., Que Areste Clinic physicians. I authorize the release of medical information to the health plan indicated as requested by the health plan to determine the payment of medical benefits.

Signature:_____ Date:_____