# Primary Care Associates P.S.

Dr. David Gamrath
Dr. Lisa Steffensen-Gamrath
Carol Turek, P.T.

4122 Factoria Blvd S.E., Suite 201
Bellevue, WA 98006
(425)865-8080

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | |
|---|---|---|---|
| (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F |
| Street address: | | | Home phone: ( ) |
| City: | State: | ZIP Code: | Mobile phone: ( ) |
| Employer: | Occupation: | | Employer phone: ( ) |

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date: / / | Address (if different): | | Home phone : ( ) |
|---|---|---|---|---|
| Employer: | Occupation: | Employer address: | | Employer phone: ( ) |
| Primary Insurance: | Subscriber's name: | Birth date: / / | Subscriber ID#: | Group #: |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
| Name of secondary insurance (if applicable): | Subscriber's name: | Subscriber ID#: | Group#: | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑Other |

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. All co-pays are due at time of service. I understand that I am financially responsible for any balance and responsible for determining what my insurance will cover and if a referral is required. I also authorize Primary Care Associates or insurance company to release any information required to process my claims. I authorize my insurance benefits be paid directly to the physician.

*Patient/Guardian signature* *Date*

Primary Pharmacy:________________ Phone#________________ Address:______________________

Secondary Pharmacy:________________ Phone#________________ Address:______________________