

# KIRKPATRICK

## FAMILY CARE

1706 Washington Way  
Longview, WA 98632  
(360) 423-9580

Primary Care Provider:

RAK  RLB  IAS  VJM   
KUT  GGK  MG

### Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Mobile Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Marital Status: Married  Single  If you checked "Married," please fill out the following information:

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone #: \_\_\_\_\_

In case of emergency, please contact the following individual: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_ Relationship to Emergency Contact: \_\_\_\_\_

### Insurance Coverage Information:

Do you have insurance coverage? Yes  No  If you checked "Yes," please fill out the following information:

Primary Insurance Company: \_\_\_\_\_ Copay Amount: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Copay Amount: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Financial Responsibility Agreement:

- I agree to pay my co-pay (if applicable) at the time of service.
- I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to the provider that rendered services.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I realize that my account may be transferred to a collection agency and my credit rating may be negatively impacted if I do not satisfy my financial responsibilities.

**Please sign below to verify that the above information is correct and that you agree to the terms of the Financial Responsibility Agreement:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If the patient is unable to sign, the parent/guardian/power of attorney may sign here instead)

**Continued on the other side...**

**If the reason that you are seeing a provider today is to discuss an accident or injury, please answer the following questions:**

1. Where were you when the accident or injury occurred?

Work  Home  Motor Vehicle\*  Other: \_\_\_\_\_

2. How did the accident or injury occur (be sure to describe the physical location of the injury)?

3. On what date did the accident or injury occur?

4. Are you responsible for the payment of treatment-related services? Yes  No

a. If you checked "No," who will be responsible for payment?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**If you checked "Work" in question 1, please continue to answer questions 5-8; otherwise, you are finished filling out this form.**

5. What is the name of your L&I Insurance? Self-Insured  WA State L&I  Other: \_\_\_\_\_

6. Have you received treatment for your accident or injury? Yes  No

a. If "Yes," at what facility did you receive treatment?

b. If "Yes," who was your health care provider?

7. Have you completed an L&I Form for this accident or injury? Yes  No

a. If "Yes," have you been assigned a claim #? Yes  No

i. If "Yes," what is your claim #?

8. Please provide the following information about your employer:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

\* All Motor Vehicle Accident (MVA) patients will be provided information instructing them to submit all billings to the auto insurance. MVA patients will be responsible for payment of all treatment-related services.