Patient Information

425.999.4503 (Office) | 425.646.4770 (Fax) 15613 Bel-Red Rd, Suite B,
Bellevue, WA 98008
Trina Seligman, N.D., L.Ac

Patient Name: _____
Last First Middle

DOB: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

_____ _____
Street address City State Zip code

_____ _____ _____
Primary phone Secondary phone Email
☐ OK to leave detailed voicemail ☐ OK to leave detailed voicemail

_____ _____ _____
Occupation Employer Spouse

_____ _____
Employer's address City State Zip code

_____ _____
Emergency contact Phone number

Do you have insurance that covers our services? ☐ Yes ☐ No

(NOTE: If a copy of your insurance card is obtained, you do not need to fill out the information below)

_____ _____
Insurance company Phone number

_____ _____
ID number Group number

_____ _____
Subscriber's name Subscriber's employer

_____/_____/_____ _____
Subscriber's DOB Relationship to patient

Assignment & Release: I hereby authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that if I suspend or terminate my care and treatment, any fees incurred by me will be immediately due and payable. Furthermore, any charges, fees, or court cost incurred as a result of collection efforts will be added to my account balance.

_____ _____
Patient Signature Patient's Guardian Signature (IF MINOR)

_____
Date