Patient Profile

Sound Health Care CENTER

PREFERRED PROVIDER

☐ Brad Frandsen, MD ☐ Carla Walter, PA –C ☐ Malia Weigelt, ARNP

PATIENT INFORMATION

Full Name

Social Security # Date of Birth (mm/dd/yyyy)

Gender: Relationship Status:

☐ Male ☐ Married ☐ Divorced ☐ Separated

☐ Female ☐ Single ☐ Widowed ☐ Other

Race:

☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander ☐ White

☐ Other Race: ☐ Decline

Mailing Address

City State Zip

Home Phone Cell Phone

Email

PREFERENCES

How would you like to be contacted?

☐ Patient Portal (secure) ☐ Home Phone

☐ Cell Phone ☐ Work Phone

How would you like to receive reminders? (i.e. annual physicals, overdue lab work, etc)

☐ Patient Portal (secure) ☐ US Mail

Are you interested in medical research opportunities? ☐ Yes ☐ No

PATIENT EMPLOYMENT

☐ Employed ☐ Retired ☐ Student ☐ Other

Employer Work Phone

EMERGENCY CONTACTS

Full Name of Primary Contact

Phone: ☐ Home ☐ Work ☐ Cell Relationship to Patient

Full Name of Secondary Contact

Phone: ☐ Home ☐ Work ☐ Cell Relationship to Patient

RESPONSIBLE PARTY

☐ Same as Patient Relationship to Patient:

Full Name

Mailing Address

City State Zip

Phone: ☐ Home ☐ Work ☐ Cell Marital Status

Employer

Social Security # Date of Birth (mm/dd/yyyy)

PRIMARY INSURANCE

Policy Holder Is: ☐ Patient ☐ Responsible Party ☐ Other

Insurance Company

Policy Number Group Number

Policy Holder's Full Name

Date of Birth (mm/dd/yyyy) Relationship to Patient

SECONDARY INSURANCE

Policy Holder Is: ☐ Patient ☐ Responsible Party ☐ Other

Insurance Company

Policy Number Group Number

Policy Holder's Full Name

Date of Birth (mm/dd/yyyy) Relationship to Patient

MEDICAID RELEASE

By signature, I verify that I am not receiving DSHS Medical Assistance and I agree to pay for services rendered. If I later become eligible for DSHS Medical Assistance, I agree to notify Sound Health Care Center as soon as I become eligible.

Signature Date

RELEASE OF BENEFITS AND INFORMATION

I consent for medical treatment and have verified the information listed on this slip and authorize my insurance benefits be paid directly to Sound Health Care Center. I am financially responsible for any balance due and understand that all charges are due and payable within 30 days following the date they are incurred. A rebilling fee of $12.00 may be added to overdue accounts. Returned NSF checks will be charged a $35 handling fee. I authorize the doctor or the insurance company to release any information required for this claim.

Signature Date