University of Washington Medical Center

PATIENT INFORMATION REQUEST

UWMC HOSPITAL NO:

INFORMATION ABOUT THE PATIENT						
Patient Name, Last First Middle	Birthdate	Social Security #		Gender M F	Race	
Marital Status	Maiden Name	Mother's Maiden Name	Father's Name	Patient Occupation	Interpreter Required Yes No	Language
Mailing Address			City		State	Zip
Home Phone Number (including area code)		Business Phone & Ext. (include area code)		Message Phone & Ext. (include area code)		

PATIENT'S MEDICARE/MEDICAID INFORMATION (if applicable)			
DSHS PIC No.	DHSH Case No.	Eligible Date (from) (to)	Pending Yes No
Medicare No.	A Effective Date	B Effective Date	Primary Coverage Yes No
L & I Claim No.	Date of Injury	Employer (L & I Injury)	

MEDICAL INSURANCE			
1. Insurance Co. Name	Address		Phone No.
Subscriber Name & ID No.	Group No.	Group Name	Employer
2. Insurance Co. Name	Address		Phone No.
Subscriber Name & ID No.	Group No.	Group Name	Employer

DENTAL INSURANCE (if applicable)			
3. Insurance Co. Name	Address		Phone No.
Subscriber Name & ID No.	Group No.	Group Name	Employer

SPOUSE/LEGAL NEXT OF KIN				
Name	Address	Relationship	Home Phone	Business Phone
Birthdate (optional)	Social Security Number (optional)			

PERSON TO NOTIFY				
Name	Address	Relationship	Home Phone	Business Phone

GUARANTOR				
Name	Address	Relationship	Home Phone	Business Phone

REFERRING PHYSICIAN/AGENCY		
Name	Address	Phone

MANAGED CARE – PRIMARY CARE PHYSICIAN		
Name	Address	Phone