Pacific Center for Neurostimulation

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
phone 206.535.6292 | fax 206.356.1151

Patient Registration

Name _____ Date of Birth _____ Social Sec.#_____

Address _____ City _____ State _____ Zip_____

Home phone _____ OK to leave message, including one with detailed clinical information Y/N

Work phone _____OK to leave message, including one with detailed clinical information Y/N

Cell / Pager _____OK to leave message, including one with detailed clinical information Y/N

Please list names of family members and friends we are able to leave a message with, including one with detailed clinical information:

_____

_____

_____

Employer _____ Marital Status _____

Your Primary Care Physician: Name _____ Clinic_____

Phone_____ Address _____ City _____

Insurance Information:

Insurance Name and Address:_____

Member/Subscriber ID:_____ Group Number_____

Emergency contact:

1. Name _____ Phone_____

Address _____ Relationship _____

2. Name _____ Phone_____

Address _____ Relationship _____

Consent for Treatment and Statement of Financial Responsibility:

I hereby give my consent for psychiatric consultation and treatment at Pacific Center for Neurostimulation. I agree to be financially responsible for all charges that accrue from consultation and treatment. I agree to be financially responsible for cancelled appointments in accordance with the clinic's cancellation policy. I have read and received Pacific Center for Neurostimulation's attached **Office Policies**, understood its contents, and agree to the terms of treatment as stated. This authorization will remain in effect indefinitely.

Name	Signature	Date