

**Kimberly Mathai, RD, CDE**

2111 N Northgate Way, Suite #217

Seattle, WA 98133

Ph: (206) 363-5420 Fax: (206) 283-2682

Patient Name: \_\_\_\_\_ SSN \_\_\_\_\_ Gender: M/F  
(LAST) (FIRST) (MI)

Birth date: \_\_\_/\_\_\_/\_\_\_ Marital Status: Single / Married / Other: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

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

Home #: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

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

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relation: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
\*\*\*If you have no insurance please specify\*\*\*

Subscriber Id #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Subscriber Employer: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Subscriber Employer: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

**FINANCIAL AGREEMENT**

The above information is true to the best of my knowledge. I understand billing my insurance is a courtesy provided to me from Kimberly Mathai, RD, CDE at no additional cost, and does not relieve my financial responsibility. I agree that Kimberly Mathai, MS, RD may furnish the responsible insurance company and other authorized parties with the necessary information to process my claims in a timely manor. I also understand that I am responsible for any non-covered services, deductibles, co-pays or co-insurances that are no covered by my insurance company. IF AN INSURANCE CARD (S) IS NOT PROVIDED AT THE TIME OF SERVICE, YOU MAY BE BILLED PRIVATELY FOR ANY SERVICES RENDERED OR YOUR APPOINTMENT MAY BE RESCHEDULED.

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