Client Registration Form

Marc Gilmartin, MA
1800 116th Ave NE, Ste. 104
Bellevue, WA 98004
425-285-8404

Date: _____

Client's Name: _____ Client's DOB: _____Age: ____

Sex: M F Gender neutral

Relationship Status: Single Married Widowed Divorced Partnered for _____ years

Address:_____
(Street) (City) (State) (Zip)

Cell: _____ Hm: _____ Wk: _____

Patient Employer/School: _____ Occupation: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Ph: _____

Emergency contact relationship: _____

I understand that services provided will need to be paid in full at time of service. I understand that the billing office will provide a monthly statement with all necessary information for me to submit claims. I will be responsible for contacting my insurance company on how to submit claims for reimbursement. Your provider accepts cash, check, HSA/FSA, debit and credit cards in his office. Any questions or concerns can be addressed with the provider and/or his billing office; Revenue Concepts, 360-625-8025.

Client's Signature: _____ Date: _____