Welcome to Puget Sound Dermatology, PLLC

21701 76th Ave W, Suite 302, Edmonds, WA 98026-7536

Patient Information

First________________________M.Initial_____Last____Gender: M F

Address____City______________________________State_________Zip _________

Home Phone___________________________ Day Phone _________________________ Date of Birth _______/_______/ _________

Social Security#________________________ Email ____

Employer____Work Phone ______________________

Marital Status: Single Married Divorced Legally Separated Life Partner Widowed

Referring Physician ____ Location: ____

Primary Care Physician_________________________________ Location: ____

Primary Insurance

Insurance Company ____

Subscriber Name: ____ Date of Birth _______/_______/______

Relationship to patient: (circle one) (a) Self (b) Spouse (c) Parent (d) Other _____________________________________

Secondary Insurance

Insurance Company ____

Subscriber Name: ____ Date of Birth _______/_______/______

Relationship to patient: (circle one) (a) Self (b) Spouse (c) Parent (d) Other _____________________________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits from my insurer, including Medicare and Medicaid, directly to Puget Sound Dermatology. By signing this form, I am accepting financial responsibility for payment of medical services provided by Puget Sound Dermatology. (A $35.00 fee will be applied to all returned checks.) I acknowledge that insurance billing service provided by Puget Sound Dermatology is a courtesy and does not relieve me of financial responsibility for services provided. This assignment of benefit shall remain in effect as long as I receive treatment from Puget Sound Dermatology.

SIGNED ____ **DATE** ____________________

PARENT OR LEGAL GUARDIAN – FOR PATIENTS UNDER 18 YEARS OF AGE

First_____________________________M.Initial_____Last____ Gender: M F

Address____City______________________________State_____Zip ________

Home Phone____________________________ Day Phone_________________________ Date of Birth ______/______/_____

Social Security#________________________ Email ____

Employer____Work Phone _________________

Relationship to patient: (circle one) (a) Subscriber is patient (b) Spouse (c) Parent (d) Other ______________________

AUTHORIZATION TO TREAT MINOR. As either the natural parent or legal guardian of the above named patient, I authorize Puget Sound Dermatology physicians to evaluate and administer medical care to my minor child. In the case of my child aged 18 or older, consent to evaluate and administer medical care is granted in accordance with my child’s personal request and need and physicians professional judgment.

SIGNED ____ **DATE** ___________________

Parent or Legal Guardian