

# Welcome to Puget Sound Dermatology, PLLC

21701 76<sup>th</sup> 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: \_\_\_\_\_

Your Preferred Pharmacy \_\_\_\_\_ Location: \_\_\_\_\_

**Primary Insurance (circle one)** (a) Health Insurance (b) PIP (auto) (c) Workers Compensation

Insurance Company \_\_\_\_\_

Subscriber Name: First \_\_\_\_\_ M.Initial \_\_\_\_\_ Last \_\_\_\_\_

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

Subscriber ID# or Claim# \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

## Secondary Insurance

Insurance Company \_\_\_\_\_

Subscriber Name: First \_\_\_\_\_ M.Initial \_\_\_\_\_ Last \_\_\_\_\_

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

Subscriber ID# or Claim# \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 16 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**