PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:
Address:	Apt#	Marital Status:
City:	State:	Zip:
Preferred Phone: ( ) **Home- Cell- Work**	Alternate Phone: ( ) **Home- Cell- Work**	
Is it okay to leave **detailed** voicemails regarding appointments, treatments, lab results, etc.? (circle one) **YES NO**		
Email:	Would you like to receive our newsletter & promotions? **YES NO**	
❑ M ❑ F	Date of Birth:	Social Security #:
Race (circle): Caucasian - Black or African American - American Indian or Alaska Native - Asian - Native Hawaiian or Other Pacific Islander - Other (indicate):		
Ethnicity (circle): Hispanic or Latino - Not Hispanic or Latino	Preferred Language:	
Referring doctor:	Primary Care Physician:	

The guarantor is always the patient, unless the patient is a minor or an incapacitated adult. The guarantor for a minor child (a child that is under 18 years of age except for an emancipated minor) is the parent/guardian that *presents the child for care at the time of the initial visit*.

Guarantor name (if different from patient):	Date of Birth:

PRIMARY INSURANCE

Insurance Name:	ID#	Group #
Subscriber Name (if different from patient):		Date of Birth:
Relationship to Subscriber:		

SECONDARY INSURANCE

Insurance Name:	ID#	Group #
Subscriber Name (if different from patient):		Date of Birth:
Relationship to Subscriber:		

EMERGENCY CONTACT

Name:	May we leave a message with this person? **Yes No**
Relationship to patient:	Phone Number: ( )

PHARMACY

Name:	Phone:

PERSONAL HEALTH INFORMATION DESIGNEE

I hereby designate the following individual(s) other than myself to receive communications from Puget Sound Dermatology that may include health information about me:

Name: _____ Relationship _____

Name: _____ Relationship:_____

CONSENT - PLEASE READ AND SIGN BELOW

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Seattle Skin & Laser or insurance company to release any information required to process my claims.

With this consent, **Puget Sound Dermatology** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, **Puget Sound Dermatology** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder and patient statements. I have the right to request that **Puget Sound Dermatology** restrict how it uses or discloses my PHI (**personal health information**) to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Patient or Responsible Party Signature:	**Date:**
Relationship to Patient (other than self)**:**	