

ADULT PATIENT REGISTRATION FORM

THIS FORM IS FOR ADULT PATIENTS WITH COMMERCIAL INSURANCE. Patients under 18 or on a parent's insurance should use the MINOR PATIENT form instead. Patients with Medicare should use the MEDICARE PATIENT form instead.

PATIENT AND PHONE INFORMATION

Bold Fields are required; others are optional.

Last Name:		First:		Middle:		Nickname, if different:	
Date of Birth (m/d/yy):		Age (in years):		Sex:		Title:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Jr <input type="checkbox"/> Dr <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Sr <input type="checkbox"/> II	
Best Phone:		Alternate Phone (if any):		Email Address (if you would like):			
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
May we leave a message at this phone number?		May we leave a message at this phone number?		May we leave a message at this phone number?		Would you like appointment reminders by email when this feature is available?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

MAILING ADDRESS

Please provide the address where bills should be mailed.

Street Address or PO Box:		Apartment Number (if any):	
City:	State:	Zip:	

FAMILY INFORMATION

If you are covered by your spouse's insurance, please make sure you provide **spouse name** and **date of birth**.

Marital Status:		Spouse Full Name (First, M.I., Last):		Spouse Date of Birth (m/d/yy):	
<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed					

May we discuss your medical condition with your spouse? Yes | No | Other named person: _____

INSURANCE INFORMATION

Please complete all information even though it may be printed on your insurance card.

1	Primary Insurance	Subscriber Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse	Subscriber ID:	Employer Name (if any):
2	Secondary Insurance	Subscriber Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse	Subscriber ID:	Employer Name (if any):

COORDINATION OF CARE

Referring Physician (name):	Phone (if you have it):
Pharmacy of Choice (name):	Phone (if you have it):

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below to acknowledge that you have received a copy of the Notice of Privacy Practices for Lake Washington Dermatology. (Your signature is only an acknowledgment of receipt, not any form of consent.)

X _____

Adult Patient Signature

Date

FOR OFFICE USE ONLY IF PATIENT REFUSES TO SIGN. I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Patient refused to sign Communications barriers Emergency situation Other (explain)

X _____

Office Employee Signature

Date

TURN OVER

