Lake Washington Dermatology ▪ 10117 NE 58th St Ste 200, Kirkland, WA 98033 ▪ (425) 821 6363 ▪ FAX (425) 821-4804

ADULT PATIENT REGISTRATION FORM

Ver 4/21/14

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:** ❑ Male ❑ Female | Title: ❑ Mr ❑ Mrs ❑ Jr ❑ Dr ❑ Ms ❑ Miss ❑ Sr ❑ II

Best Phone: ❑ Home ❑ Cell ❑ Work | **Alternate Phone** (if any)**:** ❑ Home ❑ Cell ❑ Work | Email Address (if you would like):

May we leave a message at this phone number? ❑ Yes ❑ No | May we leave a message at this phone number? ❑ Yes ❑ No | We send email and text message appointment reminders. You can opt out when you receive the first one.

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're a dependent on spouse's insurance, we need **spouse name** and **date of birth**.

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed | Spouse Full Name (First, M.I., Last): | Spouse Date of Birth (m/d/yy):

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 on your insurance card.

❶ **Primary Insurance**	**Subscriber Relationship:** ❑ Self ❑ Spouse	**Subscriber ID:**	Employer Name (if any):
❷ **Secondary Insurance**	Subscriber Relationship: ❑ Self ❑ Spouse	Subscriber ID:	Employer Name (if any):

AFFORDABLE CARE ACT INFORMATION

We have to ask these questions, but you can decline to answer.

Race: ❑ (Decline); ❑ White; ❑ Asian; ❑ Black AfrAm; ❑ Native Hawaiian or PI; ❑ Amer Indian or Nat Alaskan | **Ethnicity:** ❑ (Decline); ❑ Hispanic or Latino; ❑ Not | **Preferred Language:** ❑ Decline

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**

TURN OVER

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**