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

MINOR PATIENT REGISTRATION FORM

Ver 4/21/14

THIS FORM IS FOR PATIENTS UNDER 18 OR STILL ON PARENT'S INSURANCE. Patients over 18 and financially independent from parents should use either the ADULT PATIENT form or 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	**Name of School** (if any): ❑ Full time ❑ Part time

If the patient is under 18, please provide best ways to contact parents or guardians here.

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 mailing address for bills (NOT the minor patient's college address).

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

City:	**State:**	**Zip:**

INSURED PARENT OR GUARDIAN INFORMATION

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

	Insurance Subscriber ID:	**Parent Name** (First, M.I., Last)**:**	**Parent Date of Birth:**
❶ **Primary Insurance**			
	Subscriber is the patient's ❑ Father | ❑ Mother | ❑ Other relationship:		
❷ **Secondary Insurance**	Insurance Subscriber ID:	Parent Name (First, M.I., Last):	Parent Date of Birth:
	Subscriber is the patient's ❑ Father | ❑ Mother | ❑ Other relationship:		

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 _____ _____

Signature of Parent, Guardian, or Patient over 18 **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**