WEST SOUND DERMATOLOGY

PATIENT REGISTRATION

Date: _________________

Last Name: ____________________________ **First Name:** ___________________**MI:** ____ **Date of Birth:** _________ **Sex:** M F

Marital Status: Single Married Divorced Separated Widowed **Name of parent if patient is a minor:**_______________________

Street Address: _______________________________________ **City:** _____________________ **State:** _______ **Zip:** ____________

Preferred daytime Phone: ____________________________________ **Alternate Phone:** __________________________________

Email Address: _____________________________________ **Would you like to have access to our patient portal?** □ Yes □ No

Employer of patient *(or of parent, if patient is a minor)*: ____

Employer Address: ____

IN CASE OF EMERGENCY

In case of an emergency, who should be notified? Name: _________________________________ Relationship: ______________

Daytime Phone: ______________________________________ Alternate Phone: _______________________________________

HOW MAY WE CONTACT YOU?

Is it okay to leave a detailed message on your preferred daytime phone? □ Yes □ No

May we discuss your medical condition with another person? □ Yes □ No

If yes, whom: ___________________________________ Relationship: ________________ Phone: ____________________

How do you prefer to be contacted for appointment reminders? □ Text □ Email □ Voice

Would you like to occasionally receive information about cosmetic services and new products? □ Yes □ No

HOW DID YOU HEAR ABOUT US?

□ Doctor: ____________ □ Insurance Plan □ Hospital □ Family □ Friend □ Yellow Pages □ Internet □ Advertisement

□ Other: _______________________________________

PATIENT ACKNOWLEDGMENTS

I hereby acknowledge that I have received North Sound Dermatology's Notice of Privacy Practices (HIPAA) form and/or been given the opportunity to read it and receive a printed copy to take with me if I choose to do so. I authorize benefit claim payment to be assigned to my physician at North Sound Dermatology PC Inc and authorize the release of any medical or other information necessary to process claims. If I have not provided medical insurance, I confirm I do not have coverage to be billed and understand payment is due at the time of service.

I certify that all information provided above is accurate to the best of my knowledge.

____ ______________________________

Patient signature (*Parent or legal guardian must sign if patient is under 18*) **Date**

MEDICARE PATIENTS ONLY

Are you being seen as a result of an accident for which there is insurance coverage? □ Yes □ No

Are you 65 or older and have health insurance based on your own, or your spouse's current employment? □ Yes □ No

Are you being seen as a result of an accident that happened at work? □ Yes □ No

I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits of the benefits payable for related services.

____ ______________________________

Patient signature (*Parent or legal guardian must sign if patient is under 18*) **Date**