

NORTHWEST DERMATOLOGY & SKIN CANCER CLINIC

PATIENT REGISTRATION – PLEASE PRINT

PATIENT _____ Male Single
Last Name First Name Middle Initial Female Married

Birthdate ____ / ____ / ____ . Age ____ Soc. Sec. # _____
Mailing Address _____ Apt# _____ Home Phone _____
City, State _____ Zip _____ Business Phone _____
Employer _____ Occupation _____

* PRIMARY CARE PHYSICIAN _____

In case of emergency, local friend or relative to be notified (not living at same address).

Name _____ Relationship To Patient _____
Address _____ Phone _____

* HOW DID YOU HEAR ABOUT NW DERMATOLOGY? _____

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Name _____ Relationship To Patient _____
Mailing Address _____ DOB _____
City, State _____ Zip _____ Home Phone _____
Employer _____ Business Phone _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Patient's Relationship to Subscriber
 Self Spouse Dependent
Subscriber's Name _____ DOB _____
Subscriber ID # _____ Group # _____
Secondary Insurance Co. _____ Patient's Relationship to Subscriber
 Self Spouse Dependent
Subscriber's Name _____ DOB _____
Subscriber ID # _____ Group # _____

The above information is complete and accurate to the best of my knowledge.

I authorize treatment of the person named above, and authorize my insurance benefits to be paid directly to Northwest Dermatology & Skin Cancer Clinic for any services furnished to me by a Northwest Dermatology provider. I accept responsibility for payment of all services received from Northwest Dermatology & Skin Cancer Clinic, and understand that a finance charge of up to 1% (minimum \$5.00) will be assessed for balances over 60 days. I authorize the use and disclosure of personal health information for purposes related to payment for services.

Patient or Guarantor's Signature

Today's Date