

Dermatology of Seattle

PATIENT INFORMATION: When registering, please present proof of insurance or Medicare. Payment is expected at the time of service unless special arrangements are made.

Primary Care Provider: _____ **Phone:** _____

Referred by: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ M/F: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Phone: _____

Alt. Phone: _____

Marital Status: _____ Student? _____

Patient's Employer

Employer: _____

Phone: _____

Insurance Information

Company: _____

Group #: _____

Subscriber #: _____

Responsible Party (if other than yourself)

Name: _____

Relationship to Patient: _____ Date of Birth: _____

Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Employer: _____ Ph. _____

Other Insurance (if applicable)

Company: _____

Insured Person: _____

Phone: _____ Date of Birth: _____

Insured's Person's Address (if different than yourself):

City: _____ State: _____ Zip: _____

Social Security Number: _____

Group #: _____ Subscriber #: _____

Emergency Contact: _____ **Phone #:** _____ **Relationship:** _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Cancellation Policy

We require a 24 hr notice of cancellation. We will charge you for any missed appointment. If you miss three appointments, you will be prohibited from continuing treatment at our office.

Consent to Take Photos

I hereby consent to the taking of photographs of me by my physician. I understand that these photographs may be used as part of the medical record of my case, and that, in the judgment of my physician, medical research or teaching will benefit from their use, my physician has my consent to use or permit others to use these photographs for any medical purpose my physician deems appropriate.

Signature

Date