Dermatology Specialists of Spokane

REGISTRATION FORM

(Please Print)

Primary Care Provider:	**Today's Date:**
Referring Physician:	**Preferred Pharmacy:**

DEMOGRAPHIC PATIENT INFORMATION

Patient's last name:	**First:**	**Middle**:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid

Street Address:	**PO Box:**	**City:**	**State:**	**ZIP Code:**

SSN:	**Birth Date:** / /	**Age:**	**Gender:** ❑ M ❑ F

Occupation:	**Employer:**	**Work phone :** ( )

Primary Phone:	**Cell :**
Primary Language:	**Email:**

Preferred Communication: □ Phone □ Text □ Email | Would you like to be added to our promotional email list? □ Yes □ No

Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other Race ❑ Unknown ❑ White ❑ Declined

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑Declined

Do we have your permission to:

Leave a message on your primary phone?	❑Yes	❑No	If no, alternate #:_____
Leave a message at your place of employment?	❑Yes	❑No	If yes, work #:_____
Discuss your medical condition with any member of your household?	❑Yes	❑No	If yes, whom: _____

INSURANCE INFORMATION

Person responsible for bill:	Birth Date: / /	Address (if different):	Home phone number: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Work phone number: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance:					
Subscriber's name:	Subscriber's SSN:	Birth date: / /	Policy number:	Group number:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Insurance (if applicable):	Subscriber's name: Birth date: / /	Policy number:	Group number:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone number: ( )	

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Dermatology Specialists of Spokane and associated providers. I am financially responsible for any balance due and I have read and understand Dermatology Specialists of Spokane's Financial Agreement. I authorize the doctor or insurance company to release any information required for this medical claim. I understand that Dermatology Specialists of Spokane's Notice of Privacy Practices is posted in the office and on the website for my information and is available to me upon request.

_____ _____

Signature of Patient or Legal Guardian **Date**