Advanced Dermatology Northwest ▪ 12815 120TH Ave NE, Ste C, Kirkland, WA 98034 ▪ (425) 821-8843 ▪ FAX (425) 820-2673

ADULT PATIENT REGISTRATION FORM

THIS FORM IS FOR ADULT PATIENTS WITH COMMERCIAL INSURANCE. Patients under 18 or on a parent's insurance should use the MINOR PATIENT form instead. Patients with Medicare should use the MEDICARE PATIENT form instead.

PATIENT AND PHONE INFORMATION

Bold Fields are required; others are optional.

Last Name:	**First:**	Middle:	Prefer to be called:

Date of Birth (m/d/yy)**:**	Age (in years):	**Sex:** ❑ Male ❑ Female	Title: ❑ Mr ❑ Mrs ❑ Jr ❑ Dr ❑ Ms ❑ Miss ❑ Sr ❑ II

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	Would you like appointment reminders by email when this feature is available? ❑ Yes ❑ No

MAILING ADDRESS

Please provide the address where bills should be mailed.

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

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

FAMILY INFORMATION

If you are covered by your spouse's insurance, please make sure you provide **spouse name** and **date of birth**.

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed	Spouse Full Name (First, M.I., Last):	Spouse Date of Birth (m/d/yy):

May we discuss your medical condition with your spouse? ❑ Yes | ❑ No | Other named person:

INSURANCE INFORMATION

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

❶ **Primary Insurance**	**Subscriber Relationship:** ❑ Self ❑ Spouse	**Subscriber ID:**	Employer Name (if any):
❷ **Secondary Insurance**	Subscriber Relationship: ❑ Self ❑ Spouse	Subscriber ID:	Employer Name (if any):

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 _____ _____

Adult Patient Signature **Date**

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**