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

MEDICARE PATIENT REGISTRATION FORM

THIS FORM IS FOR ADULT PATIENTS WITH MEDICARE. Patients under 18 or on a parent's insurance should use the MINOR PATIENT form instead. Adult patients who do not have Medicare should use the ADULT 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 also covered by an employed spouse's insurance, or if your spouse is an existing patient with us, please 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:

MEDICARE AND OTHER INSURANCE INFORMATION

Please check **only ONE** of these options to explain how we should set up your Medicare and other (if any) insurance.

❑ Medicare Part B primary with other insurance secondary.	❑ Medicare Advantage Plan (claims not sent to Medicare).
❑ Medicare Part B only (you are responsible for paying your $135 annual deductible and 20% coinsurance).	❑ Other insurance primary with Medicare Part B secondary (you are employed, for example).

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**