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

MINOR PATIENT REGISTRATION FORM

THIS FORM IS FOR PATIENTS UNDER 18 OR STILL ON PARENT'S INSURANCE. Patients over 18 and financially independent from parents should use either the ADULT PATIENT form or the MEDICARE PATIENT form instead.

PATIENT AND PHONE INFORMATION

Bold Fields are required; others are optional.

Last Name:	**First:**	Middle:	Nickname, if different:

Date of Birth (m/d/yy)**:**	Age (in years):	**Sex:** ❑ Male ❑ Female	**Name of School** (if any): ❑ Full time ❑ Part time

If the patient is under 18, please provide best ways to contact parents or guardians here.

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 (NOT the minor patient's college address, for example).

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

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

INSURED PARENT OR GUARDIAN INFORMATION

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

	Insurance Subscriber ID:	**Parent Name** (First, M.I., Last)**:**	**Parent Date of Birth:**
❶ **Primary Insurance**			
	Subscriber is the patient's ❑ Father | ❑ Mother | ❑ Other relationship:		
❷ **Secondary Insurance**	Insurance Subscriber ID:	Parent Name (First, M.I., Last):	Parent Date of Birth:
	Subscriber is the patient's ❑ Father | ❑ Mother | ❑ Other relationship:		

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 _____ _____

Signature of Parent, Guardian, or Patient over 18 **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**