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 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:

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/text? ❑ 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/parent's insurance, please make sure you provide **their name** and **date of birth**.

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed	Spouse or Parent Full Name (First, M.I., Last):	Spouse or Parent 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/Parent	**Subscriber ID:**	Employer Name (if any):
❷ **Secondary Insurance**	Subscriber Relationship: ❑ Self ❑ Spouse/Parent	Subscriber ID:	Employer Name (if any):

COORDINATION OF CARE

Referring Physician (name)**:**	Phone (if you have it):

Pharmacy of Choice (name and address)**:**	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 Advanced Dermatology Northwest. (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**

ONCE COMPLETED, PLEASE EMAIL FORM TO: CONTACTUS@ADVANCEDERMNW.COM