PENINSULA DERMATOLOGY & LASER CLINIC
Silverdale Gig Harbor Tacoma

Patient Information

Personal Information

Name: _____ **Gender:** _____

Date of Birth: _____ **Age:** _____

Address: _____

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

Home Phone: _____ **Cell Phone:** _____

Parent / Guardian (if patient is a minor)

Name: _____ **Phone:** _____

Employer: _____ **Occupation:** _____

Emergency Contact

Name: _____ **Phone:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Insurance

PRIMARY: _____ **ID #:** _____

Group #: _____ **Subscriber:** _____

Relationship: _____ **Subscriber DOB:** _____

SECONDARY (billed as a courtesy)

Name: _____ **ID #:** _____

Group #: _____ **Subscriber:** _____

Relationship: _____ **Subscriber DOB:** _____

Please Read Carefully Before Signing

Co-Pays and Deductibles: It is the responsibility of the patient to know their co-pay and deductible. Your insurance plan is a contract between you and your insurance provider. WE DO NOT KNOW WHAT YOUR DEDUCTIBLE IS! Procedures done in office are often classified as surgical codes and may be subject to your deductible. If you have not met your deductible, you may receive a bill for services or treatments rendered. Initials: _____

Assignment, Release and Financial Agreement: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment of any of my charges. I have also been informed of the $35.00 fee (per RCW 62A.2-515&520) on checks returned for NSF. In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and other costs the court determines proper.

Medicare Authorization: I authorize the doctor to release to the Federal Government or its designated agent information on this or related medical claims. I permit a copy of this authorization to be used in place of the original and request payment of my insurance benefits be made to myself or to the doctor if assignment is accepted. Lifetime authorization.

Phone Messages: I authorize Peninsula Dermatology to leave messages at my home or alternate number I have provided for all administrative issues. Privacy: We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. A signature below acknowledges that you have been given the opportunity to review and/or receive a copy of the NOTICE OF HEALTH INFORMATION PRACTICES of Peninsula Dermatology & Laser Clinic.

Patient or Guardian Signature: _____ **Today's Date:** _____

Do you authorize our office to discuss your information with other family members?

Name(s) of family members: _____

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Silverdale Gig Harbor Tacoma

Patient History

Name: _____ **Date:** _____

Date of Birth: _____ **Gender:** _____

Marital Status: _____ **Occupation:** _____

Home Phone: _____ **Cell Phone:** _____

History of Skin Cancer: Y / N **Type:** _____

Family History of Skin Cancer: Y / N **Type:** _____

Medication Allergies: _____

Current Medications: _____

Operations: _____

Family History Diseases: _____

Hobbies/Activities: _____

Illness / Symptom	Y / N	Explanation of Illness/Symptoms
Blood / Bleeding Disorder		
Cancer		
Diabetes / Thyroid		
Eyes / Glaucoma		
Ear / Nose / Mouth / Throat		
Lung Disease / Asthma		
Epilepsy / Seizure		
Stroke / Neurological		
Kidney / Urinary		
Liver / Hepatitis		
Heart Disease / Angina		
High Blood Pressure		
Stomach / Gastrointestinal		
Chronic Viral Infections		
Circulation Disorder		
Arthritis		
Skin		
Psychiatric / Depression		
Pacemaker		
Artificial Joint(s)		
Anticoagulants (aspirin, etc)		
Tobacco		
Alcohol		