PENINSULA
DERMATOLOGY
and laser clinic

PATIENT INFORMATION SHEET

USE LEGAL NAME AS IT APPEARS ON YOUR INSURANCE CARD

Name:			☐ Male ☐ Female
Birth Date	/ / Age:		
Billing address:			
City:	State: Zip:		
Home Phone	- - ☐ Primary	Cell Phone:	- - ☐ Primary
Work Phone:	- - ☐ Primary		
PARENT/GUARDIAN IF PATIENT IS A MINOR			
Name:		Home Phone:	- -
Employer:		Cell Phone:	- -
Occupation:		Work Phone:	- -
EMERGENCY CONTACT:		Relationship:	
Name:		Phone:	- -
REFERRING PHYSICIAN:			
INSURANCE INFORMATION: Although we have taken copies of your cards we do need this filled out for your chart –Thank you			
PRIMARY:		Group Number:	
ID #:		Subscriber:	
Relationship:		Date of birth:	
WE BILL SECONDARY INSURANCE ONCE AS A COURTESY TO YOU			
Secondary:		Group Number:	
ID #:		Subscriber:	
Relationship:		Date of birth:	

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Co-Pays and Deductibles: It is the responsibility of the patient to know their co-pay, and their 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, then you may receive a bill for services or treatments rendered to you.

_____ **(please initial)**

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 am financially responsible for a billing fee and understand that balances over 60 days may incur a billing fee of $5.00 per month, with a minimum charge of $10.00 monthly. I have also been informed of the $25.00 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 ☐ Ending ___/___/___

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 only acknowledges that you have been given the opportunity to review and/or to receive a copy of the NOTICE OF HEALTH INFORMATION PRACTICES OF Peninsula Dermatology & LASER CLINIC.

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

Print Name:_____

! Do you authorize our office to discuss your information with other family members ☐ Yes ☐ N

Names of family members_____

Updated 06/15/2012

Patient Personal history

Date:_____/_____/_____

Name:			☐ Single ☐ Married ☐ Widowed ☐ Partnered
Occupation:		Employer:	
Home Phone:	- - ☐ Primary	Sex:	☐ Male ☐ Female
Cell Phone:	- - ☐ Primary	Birth Date:	/ / Age:
Work Phone:	- - ☐ Primary		
History of Skin Cancer: ☐ Yes ☐ No If yes please list type:		Family History of Skin Cancer: ☐ Yes ☐ No If yes please list type:	
Allergies to Medications:			
Current Medications:			
Operations:			
Family History (Illnesses):			
Hobbies/Activities:			

Illnesses/Symptoms		Please Explain Nature of Illness/Symptoms
Blood/bleeding disorders	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Diabetes/thyroid	☐ Yes ☐ No	
Eyes/glaucoma	☐ Yes ☐ No	
Ear/Nose/mouth/throat	☐ Yes ☐ No	
Lung Disease/Asthma	☐ Yes ☐ No	
Epilepsy/Seizures	☐ Yes ☐ No	
Stroke/Neurological	☐ Yes ☐ No	
Kidney/urinary	☐ Yes ☐ No	
Liver/Hepatitis	☐ Yes ☐ No	
Heart disease/Angina	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
Stomach/Gastrointestinal	☐ Yes ☐ No	
Chronic viral infections	☐ Yes ☐ No	
Circulation Disorder	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Psychiatric/depression	☐ Yes ☐ No	
Pacemaker	☐ Yes ☐ No	
Artificial Joints	☐ Yes ☐ No	
Anticoagulants (also aspirin)	☐ Yes ☐ No	

Tobacco ☐ Yes ☐ No Alcohol ☐ Yes ☐ No (AMT) _____