OLYMPIC DERMATOLOGY
Medical & Cosmetic Excellence

ID#:

Today's Date _____

Title _____ **Nickname** _____

Legal Name _____
First MI Last

Mailing Address _____ Apt # _____

_____
City State Zip

SS#: _____ **Gender** _____
(or copy of driver's license)

Date of Birth _____ **Spouse's Name** _____

Marital Status _____ **Spouse's DOB** _____

PHONE NUMBERS

Home _____

Work _____ Ext: _____

Cell _____

Which Do You Prefer? _____

Email _____

May we leave a medical message on voicemail?
☐ YES ☐ NO

EMERGENCY CONTACT

Name: _____
First Last

Relationship: _____

Home #/Work # _____

PCP/REFERRAL

Referring Provider: _____
(First/Last Name/City)

Primary Care Provider: _____
(First/Last Name/City)

_____

EMPLOYMENT

Occupation: _____

Company: _____

Address: _____

□ **Student** □ **Retired**

OTHER

Race: _____

Ethnicity: _____

Language: _____

LEGAL GUARDIAN OR PARENT (IF APPLICABLE)

Name: _____ **DOB:** _____ **Gender:** _____ **Relationship:** _____
First Last

Address: _____ **SS#:** _____
(If different from above) City State Zip

INSURANCE INFORMATION

❒ **I have no insurance** ❒ **I have single coverage** ❒ **I have double coverage**

Primary Insurance Name: _____

Name of Subscriber: _____

Subscriber's DOB: _____

ID#: _____ Group #: _____

Relationship to the insured: _____

Secondary Insurance Name: _____

Name of Subscriber: _____

Subscriber's DOB: _____

ID#: _____ Group #: _____

Relationship to the insured: _____

Please complete this section if you have already presented your insurance card(s) to the office

OFFICE POLICIES

Thank you for choosing Olympic Dermatology & Laser Clinic. We have set forth a few of our policies which we hope will guide you during your time with our office. We are committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our policies is important to our professional relationship. Please ask if you have any questions about our fees, policies or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

By my signature below I acknowledge the information on both sides of this form is current and accurate. I have read and understand the Office Policies of Olympic Dermatology and Laser Clinic dated 2/1/2019. We are happy to provide you with a full copy of our Office Policies or it may be accessed on our website at www.olympicdermatology.com.

If you are unable to keep an appointment, we ask for 24 hours' notice of cancellation to avoid a possible $45 charge, which is not covered by your insurance. Missed surgery appointments will be charged $75.00. Our cosmetic appointments require a $100 deposit which may be forfeited for late cancellation or no show. We do attempt to remind you of your appointments, but it is strictly a courtesy contact.

I authorize payment of medical benefits to the physician. I understand my portions of the fees are expected at the time of service. Effective January 1, 2008, any balances that aren't paid within 30 days of the first statement are subject to 1% per month interest (12% APR). In the event of default of payment and/or failure to pay, I agree to pay the costs of collection including court costs and reasonable attorney fees to be determined by a court of law. (I realize I will be discharged from the practice.) Any unresolved claims will be pursued in Thurston County court system.

DO WE HAVE PERMISSION TO RELEASE YOUR PRIVATE HEALTH INFORMATION?

☐ No - Do not release my information to anyone
☐ Yes - You may release my private health information to:

Name _____ Relationship _____

Name _____ Relationship _____

WHAT INFORMATION MAY WE RELEASE?

☐ All protected health information
☐ Other. Please specify: _____

Patient or legally authorized individual signature _____ **Date** _____

Printed name if signed on behalf of the patient _____ Relationship (parent, guardian, personal Rep.) _____

FOR OFFICE USE ONLY:

Initials _____ Date _____