



**PATIENT INFORMATION SHEET**  
**USE LEGAL NAME AS IT APPEARS ON YOUR INSURANCE CARD**

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

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

**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 \$1.00 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

❖ **Do you authorize our office to discuss your information with other family members**  Yes  No

**Names of family members** \_\_\_\_\_

## Patient Personal history

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

|  |  |   |
|--|--|---|
| <b>Name:</b>   |  | <input type="checkbox"/> Single <input type="checkbox"/> Married    |
|  |  | <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered |
| Occupation:  | Employer:  |   |
| Home Phone:    -    - <input type="checkbox"/> Primary   | Sex:   | <input type="checkbox"/> Male <input type="checkbox"/> Female       |
| Cell Phone:    -    - <input type="checkbox"/> Primary   | Birth Date:  | /    /    Age:  |
| Work Phone:    -    - <input type="checkbox"/> Primary   |  |   |
| <b>History of Skin Cancer:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please list type:                              | <b>Family History of Skin Cancer:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please list type: |   |
| <b>Allergies to Medications:</b>   |  |   |
| <b>Current Medications:</b>  |  |   |
| <b>Operations:</b>   |  |   |
| <b>Family History (Illnesses):</b>   |  |   |
| <b>Hobbies/Activities:</b>   |  |   |
| <b><u>Illnesses/Symptoms</u></b>   | <b><u>Please Explain Nature of Illness/Symptoms</u></b>  |   |
| Blood/bleeding disorders <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Diabetes/thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Eyes/glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Ear/Nose/mouth/throat <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Lung Disease/Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Stroke/Neurological <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Kidney/urinary <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Liver/Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Heart disease/Angina <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Stomach/Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Chronic viral infections <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Circulation Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Skin <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Psychiatric/depression <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____  |   |
| Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Anticoagulants (also aspirin) <input type="checkbox"/> Yes <input type="checkbox"/> No   | _____  |   |
| Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No    Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No (Amt) _____ |  |   |