Patient Registration — Norris Dermatology and Laser Northwest — **Date:**________________

Patient Information (please print)

Name: ____
Last First Middle

Address: ____
Street Apt. # City State Zip

Primary Telephone:__________________ Alternate Telephone: __________________ Sex: M F

Date of Birth: __________________ E-mail Address: __________________

Employer: __________________ Telephone (Work): __________________

Occupation:__________________ Marital Status: (optional) S M D W Sep

Spouse Name:__________________ Spouse Occupation & Employer:__________________

Responsible Party (person responsible for payment) ❑ *Same as above*

Name: __________________ Relationship: __________________

Home Address: ____

Home Phone #: __________________ Business Phone #: __________________

Employer: __________________ Occupation:__________________

Referring Physician: ____

Address: ____

Primary Care Physician: ❑ Same__________________ Address: __________________

Primary Insurance

Insurance Name: __________________ Co-pay $: ____________ DOB____________

Policy Holder/Subscriber Name:__________________ Relationship:__________________

Insurance Address: ____

ID # or Social Security #: __________________ Group or Plan #: __________________

Medicare #: __________________ Oregon Health Plan #: __________________

Secondary Insurance (if applicable)

Insurance Name: __________________ Co-pay $: ________________

Policy Holder/Subscriber Name (if different):__________________ Relationship:__________________

Insurance Address: ____

ID # or Social Security #: __________________ Group or Plan #:__________________

Personal Information

In case of emergency, notify: ____________________________ Phone #:_______________________________

Do you give our office permission to discuss your medical information with family members? ☐ **Yes** ☐ **No**

If yes, please provide their names and phone numbers below.

Name: ____ Relationship: ____________________________

Phone # (Day): ( ) ___________________________ Phone # (Evening): ( ) ___________________________

May we leave personal information on your voicemail/phone? ☐ **Yes** ☐ **No**

CONSENT FOR TREATMENT: I authorize Norris Dermatology and personnel to provide ongoing medical care, treatment and procedures. I acknowledge that no guarantee can or will be made as to the result of the care, treatment and medication prescribed.

Date: __________________________ ____

Signature of Patient or Legally Authorized Representative

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Name & relationship to patient, if not signed by the patient

Credit Policy

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by Norris Dermatology and personnel. As a service, we bill most insurance companies directly, except those outside the country. Providing accurate and current insurance information is the responsibility of the patient. Please notify us of any changes at each visit.

Payment: Payment is due within 30 days of the first billing unless other arrangements are made. It is our policy to charge a $25.00 fee on all returned checks.

Medicare: Dr. Norris is a participating provider and we will bill Medicare as your primary insurer. Note: Medicare may also be able to bill your supplemental insurance. Please contact them at 1-800-326-0238.

Oregon Welfare and Oregon Health Plan: Please bring your current medical card with you each visit. If you are restricted to a primary care physician by OMAP, you must obtain a referral from this physician for you to see Norris Dermatology and personnel.

❑ I am supplying Norris Dermatology's office with insurance information. I authorize my insurance company to pay directly to Dr. Norris all benefits due for my medical care, and hereby consider this an assignment of benefits. I authorize Norris Dermatology to provide all information my insurance company(s) request concerning my treatment.

If my insurance company requires a referral from my primary care provider and I did not obtain a referral prior to my appointment, I understand my visit may be rescheduled until the referral is obtained.

I agree to pay for all services not covered or allowed by my insurance company (including deductibles and copays). Any money received in excess of charges will be refunded when my bill is paid in full.

❑ I am not supplying Norris Dermatology's office with insurance information. I understand that I am financially responsible for services performed. I understand and comply with the credit policies of the office of Norris Dermatology.

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Signature of Patient Date