Norris Dermatology and Laser Northwest

☐ New Patient
☐ Update/Review

DATE: _____

PATIENT REGISTRATION		
Name *(Last, First, M.I.):*		**DOB:**
Address:		**City, State Zip:**
Home Phone: ☐ Preferred	**Cell Phone:** ☐ Preferred	**Work Phone:** ☐ Preferred
Email	☐ I would like to be web-enabled for the patient portal and receive my results, office visit summary's and schedule appointments online	
Sex: ☐ Male ☐ Female ☐ Transgender ☐ Other/prefer not to disclose		
Race: ☐ Other/prefer not to disclose	**Ethnicity:** ☐ Other/prefer not to disclose	
Language: ☐ Other/prefer not to disclose		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other		
Employment status: ☐ Employed ☐ Part-time Employed ☐ Full-time Student ☐ Retired ☐ Unemployed ☐ Other		
Primary Care Provider:	**PCP Phone Number:**	
☐ **Please check box if it is okay to share medical records between my medical providers when possible**		
How were you referred to our office? ☐ Patient ☐ Doctor/Provider ☐ Self	**Please Print Here:**	

EMERGENCY CONTACT	
Name *(Last, First, M.I.):*	**Phone:**
Address *(optional):*	

HOW WOULD YOU LIKE TO BE CONTACTED WITH PROCEDURE/LAB RESULTS
☐ **Telephone** ☐ **Okay to leave a detailed voicemail with results**
☐ **Online through the patient portal** (please be sure you are web-enabled above)
☐ **Okay to speak with the following people regarding medical/appointment information** *(Please list below)*

INSURANCE INFORMATION	
Name of primary policy holder *(and relationship to patient):*	**DOB:**
Insurance Company:	
(IF YOUR INSURANCE CARD WAS SCANNED PLEASE SKIP TO THE NEXT SECTION)	
ID Number:	**Group Number:**
Address:	**City, State Zip:**

SECONDARY INSURANCE INFORMATION	
Name of primary policy holder *(and relationship to patient):*	**DOB:**
Insurance Company:	

(IF YOUR INSURANCE CARD WAS SCANNED PLEASE SKIP TO THE NEXT SECTION)	
ID Number:	**Group Number:**
Address:	**City, State Zip:**

PLEASE COMPLETE THE FOLLOWING FOR CHILDREN UNDER 18 YEARS OF AGE	
Parent/Guardian Name:	**Phone:**
Parent/Guardian Name:	**Phone:**

CONSENT TO TREATMENT

Permission is given to Patricia Norris, MD and staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. We will be happy to discuss your concerns at any time. During your visit your health and safety are our main concern. We usually recommend a full skin examination for patients who are new to our office to search for and document benign and potentially malignant skin lesions. You can opt out of a full skin examination if you wish, but we recommend it at least once a year, especially if you have had a previous skin cancer. If a suspicious appearing or concerning skin lesion is discovered, a biopsy or surgical excision may be recommended. As with all medical and surgical procedures there are risks of scarring, infection at the surgical site, bleeding, allergic reaction to anesthesia, acute or chronic pain, and slow healing, especially on lower extremities and feet. We always do our best to minimize side effects and scarring, but scars and keloids can occur, and are more likely with removal of large skin cancers on the upper torso and face, even under the best surgical conditions. We want you to ask any and all questions that you may have regarding your skin treatment and surgical procedures, especially about the risks and alternative treatments that may be available, and we hope you will not hesitate to inquire. Our goal is to provide the very best care possible for your skin conditions, and to work together with you as a team and assure your skin health.

FINANCIAL RESPONSIBILTY AND ASSIGNMENT OF BENEFITS

☐ I **am** supplying Norris Dermatology and Laser NW with insurance information. I authorize my insurance company to pay directly to Norris Dermatology and Laser NW all benefits due for my medical care, and hereby consider this an assignment of benefits. I authorize Norris Dermatology and Laser NW to provide all information my insurance company requests concerning my treatment. If my insurance company requires a referral from my primary care physician and I did not obtain a referral prior to my appointment, I am financially responsible for all services. It is understood that I am financially responsible for all services not covered or allowed by my insurance company, including out of office services such as pathology services and lab testing (also including deductibles and co-pays). Any money received in excess of my charges will be refunded when my bill is paid in full. I understand that if I do not show up for an appointment, or if I cancel with less than 24 hours' notice, I may be assessed a fee.

-OR-

☐ I am **not** supplying Norris Dermatology and Laser NW with insurance information. I understand that I am financially responsible for all services performed. I understand and will comply with the financial policy of Norris Dermatology and Laser NW.

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

By signing below, I certify that I have read this form and understand its contents:

_____ _____

Patient or legally authorized person Date