LAKE OSWEGO DERMATOLOGY GROUP

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PATIENT INFORMATION FORM

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/___/____

Name: ____
Last First M.I.

Date of Birth: _____/_____/_____ Age_____ Social Security # ______________________ Sex: ☐ Male ☐ Female

ADDRESS:

Mailing Address: ____
City State Zip
Home Phone: ( ) ________________________ Work Phone: ( ) ____________________________
Cell Phone: ( ) _________________________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referred by: ____

Primary Care Physician: ____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: ______________________________________ Date Of Birth: _____/_____/_____
Last First M.I.

Address: ____
City State Zip
Home Phone: ( ) ________________________ Work Phone: ( ) ____________________________

INSURANCE COVERAGE – PRIMARY:

Insurance Co. Name: ____________________________ Phone: ( ): ___________________ Ext: _____

Address of Claims Center: ____

City State Zip
Name of Policy Holder (Insured): ____
Policy Holder (Insured) Date of Birth: ____/____/____ SS# ___________________ Sex: ☐ Male ☐ Female
Policy #: __________________________________ Group Name or #: _______________________
Policy Type: ☐ HMO ☐ PPO
Employer Name: ____
Employer Address: ____
If patient is a child, check relationship: ☐ Mother ☐ Father ☐ Other: _____________________________

INSURANCE COVERAGE – SECONDARY:

Insurance Co. Name: ____________________________ Phone: ( ): ___________________ Ext: _____

Address of Claims Center: ____

Policy Holder (Insured) Date of Birth: ____/____/____ SS# ____________________ Sex: ☐ Male ☐ Female
Policy #: ____ Group Name or #: ________________________
Policy Type: ☐ HMO ☐ PPO
Employer Name: ____
Employer Address: ____
If patient is a child, check relationship: ☐ Mother ☐ Father ☐ Other: ______________________________

Other family members that are patients: ____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? ____

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 answering machine at home?

☐ **YES** ☐ **NO**

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature ____ Date ___/___/___

PAYMENT POLICY:

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, co-payment and charges for **any non-covered, cosmetic services**.

Patient or Responsible Party Signature ____ Date ___/___/___