TRI-CITY DERMATOLOGY

112 Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
Fax: (509) 818-1303

PATIENT REGISTRATION

(PLEASE PRINT)

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Birth Sex: M_____ F_____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ Age: _____

Home Phone #: _____ Cell Phone #: _____ Preferred Phone #: home/cell

OK to leave message? ☐Yes ☐No Email: _____

Race/Ethnicity: ☐American Indian ☐Asian ☐Black ☐Hispanic/Latino ☐Pacific Islander ☐White ☐Other _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Preferred Pharmacy: _____

For Minor Patients Only: *All minor visits require a legal guardian.

Parent/Guardian #1: _____ Relationship: _____ Phone (cell/home): _____

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Disclosure of Protected Health Information (PHI) and Billing or Payment Information (optional):

I authorize disclosure of my PHI and/or billing and payment information to the following individual(s):

Name: _____ Relationship: _____ Phone (cell/home): _____ ☐PHI ☐Billing

Name: _____ Relationship: _____ Phone (cell/home): _____ ☐PHI ☐Billing

INSURANCE INFORMATION

Primary Insurance Policy:

Primary Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____ Group # (if applicable): _____

Secondary Insurance Policy:

Primary Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____ Group # (if applicable): _____

Patient Signature (or legal guardian): _____ **Date:** _____