

# Dermatology Northwest

Carolyn I. Hale M.D.  
Joel James, PA-C  
Julie Miller, R.N., B.S.N., D.N.C., M.E.P.C

5900 Inland Shores Way, Suite 202  
Keizer, Oregon 97303  
Phone 503-463-6799  
Fax 503-463-6771  
www.dermatologynw.com

## **Patient Registration, (Please Print)**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Ethnicity \_\_\_\_\_ (Hispanic, Non-Hispanic, Unknown) Race \_\_\_\_\_ Primary Language \_\_\_\_\_  
Primary MD \_\_\_\_\_ Referral MD \_\_\_\_\_  
Pharmacy (Local) \_\_\_\_\_ City \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

## **Emergency Contact**

Name \_\_\_\_\_ Relation \_\_\_\_\_  
Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

## **Insurance Information**

### **Primary**

Insurance Company \_\_\_\_\_  
Policy Holders Name \_\_\_\_\_  
Birthdate of Policy Holder \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### **Secondary**

Insurance Company \_\_\_\_\_  
Policy Holders Name \_\_\_\_\_  
Birthdate of Policy Holder \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### **Guarantor Information** (Parent initiating care for persons less than 18 years of age)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation \_\_\_\_\_  
Address (If different than patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

*If you would like to receive notification of specials and promotions, please provide us with your email address: \_\_\_\_\_ . Please "like us" on Facebook and receive notification of specials and cosmetic promotions. Find us under Dermatology Northwest and select the location where we see you.*