Michele M. Thompson, MD
DERMATOLOGY
*1499 SE Tech Center Place, Suite 135, Vancouver, WA 98683 | phone: 360.450.6800 | fax: 360.989.1150*

## DEMOGRAPHIC INFORMATION

Full Name: ______________________________________________ Gender: __Male __Female

D.O.B.:_____/_____/________ How did you hear about us:___________________________________

Address: ____________________________________________________________________
Street City State Zip Code

Primary phone: (____)______-_________ [] cell [] home [] business

Secondary phone: (____)______-_________ [] cell [] home [] business

Email:_______________________________________________ Marital status:______________

May we leave detailed messages, test results, or medical information on your voicemail? __Yes __No

How do you prefer to receive appointment reminders: [] text [] email [] phone call

**Affordable Care Act:** *Federal law mandates we ask these questions, but you may decline to answer.*

Race: _(decline) _White _Asian _Black AfrAm _Native Hawiian or PI _Am. Indian or Nat. Alaskan

Ethnicity: _(decline) _Hispanic or Latino _NOT Hispanic or Latino

Preferred language:__________________________________________________________

**Financially Responsible Party if other than self**: Name: ________________________________

Occupation/ Employer: ___________________ Relationship:___________________________

**Referring Physician:** ___________________________________ Phone: (______)______-_________
FIRST NAME LAST NAME

**Primary Care Physician:** ___________________________________ Phone: (______)______-_________
FIRST NAME LAST NAME

**Emergency Contact:** _____________________________________ Phone: (______)______-_________

Relationship: _____________________________________________

*With whom do you give our office permission to discuss your medical information?* __No One

Name: _________________________ Phone: (______)______-_________ Relationship:__________

# Michele M. Thompson, MD

D E R M A T O L O G Y

*1499 SE Tech Center Place, Suite 135, Vancouver, WA 98683 | phone: 360.450.6800 | fax: 360.989.1150*


**Primary Insurance:____________________** Member ID Number: ____________________________

Policy holder:__________________________________________________________________________

Name DOB SSN

Relationship to patient: __Self __Parent __Spouse __Other: _________________________________

**Secondary Insurance:_________________** Member ID Number: ____________________________

Policy holder:__________________________________________________________________________

Name DOB SSN

Relationship to patient: __Self __Parent __Spouse __Other: _________________________________

I attest that the information provided is to the best of my knowledge, true and accurate. I authorize Michele M. Thompson, MD LLC to release medical information necessary to process my insurance claim (if any). I herein authorize payment of medical benefits to Michele M. Thompson, MD LLC when assigned claim is filed. I understand that I am responsible any amount not paid for by my insurance. I understand I am responsible for any known visit co-pays at the time of service.

By signing this form, I authorize the physicians, agents and employees of Michele M. Thompson, MD LLC to provide medical or surgical care and services, including, but not limited to, diagnostic tests, examinations and other medical and surgical procedures in the course of my medical care. I agree to comply with the plan of care/ services to which I have consented. I agree I have reviewed and understand the Notice of Privacy Practice (HIPAA). A paper copy has been offered to me.

_______________________________________________ ________________________________

Patient or Responsible Party Signature Date