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: ____

Address: ____
Street City State Zip Code

Email:____

D.O.B.:_____/_____/________ Primary phone (____)______-________ [] cell [] home [] business

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

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

Gender: __Male __Female Marital status:______________

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

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:____

Emergency Contact: ________________________________ Phone: (______)______-________

Relationship: ______________________________________ [] cell [] home [] business

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

Name: ______________________ Phone: (______)______-________ Relationship:__________

Financially Responsible Party if other than self: Name: ________________________________

Occupation/ Employer: ________________ Relationship:________________________

How did you hear about us:______________________________

Primary Care Physician: ______________________________ Phone: (______)______-________
FIRST NAME LAST NAME

Referring Physician: ______________________________ Phone: (______)______-________

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FIRST NAME LAST NAME

IN ORDER TO BILL YOUR INSURANCE WE MUST HAVE THE SUBSCRIBERS INFORMATION BELOW

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 hereby 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