

**NORTH IDAHO DERMATOLOGY**  
2288 N. Merritt Creek Loop • Coeur d'Alene, Idaho 83814  
Ph. (208) 665-7546 • Fax (208) 667-4607

**PATIENT INFORMATION**

**Patient** \_\_\_\_\_  
Last Name First Name Middle Initial

**Mailing Address** \_\_\_\_\_  
Street Apt# City State Zip

**Home Phone** ( ) \_\_\_\_\_ **Cell Phone** ( ) \_\_\_\_\_ **Work Phone** ( ) \_\_\_\_\_

**Birth date** \_\_\_\_\_ **Age** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Sex:**  Male  Female **Marital Status:**  Single  Married  Widowed  Divorced  Separated

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

Winter Address:  Yes  No Email Address \_\_\_\_\_

If you answer yes, it is your responsibility to give North Idaho Dermatology the forwarding information

**BILLING INFORMATION**

**PERSON RESPONSIBLE FOR ACCOUNT** (If different from patient)

\_\_\_\_\_  
First Name Middle Initial Last Name

**Mailing Address** \_\_\_\_\_  
Street Apt# City State Zip

**Home Phone** ( ) \_\_\_\_\_ **Cell Phone** ( ) \_\_\_\_\_ **Work Phone** ( ) \_\_\_\_\_

**Birth date** \_\_\_\_\_ **Age** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Sex:**  Male  Female **Relationship to Patient:** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**REFERRED BY:**

Physician who referred you: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

May we leave a message on your phone? .....  Y  N

If employed, may we leave a message at your place of employment? .....  Y  N

Is there anyone else we can talk to other than the patient? (please list below) .....  Y  N

**If yes, whom?**

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

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**INSURANCE INFORMATION**

You must show your insurance card(s) to the receptionist before a claim will be submitted to your insurance. Your bill will be generated by North Idaho billing office.

NO INSURANCE

**PRIMARY INSURANCE**

Name of Primary Insurance \_\_\_\_\_

Insurance Address \_\_\_\_\_  
(Where claims are to be sent) Street City State Zip Phone #

Policy Owner \_\_\_\_\_  
Name Relationship Date of Birth (mm/dd/yyyy) Social Security #

Policy Owner Address \_\_\_\_\_  
(If different from patient) Street City State Zip Phone #

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ CO-PAY \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Primary Insurance \_\_\_\_\_

Insurance Address \_\_\_\_\_  
(Where claims are to be sent) Street City State Zip Phone #

Policy Owner \_\_\_\_\_  
Name Relationship Date of Birth (mm/dd/yyyy) Social Security #

Policy Owner Address \_\_\_\_\_  
(If different from patient) Street City State Zip Phone #

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ CO-PAY \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

**ADDITIONAL INSURANCE**

Name of Primary Insurance \_\_\_\_\_

Insurance Address \_\_\_\_\_  
(Where claims are to be sent) Street City State Zip Phone #

Policy Owner \_\_\_\_\_  
Name Relationship Date of Birth (mm/dd/yyyy) Social Security #

Policy Owner Address \_\_\_\_\_  
(If different from patient) Street City State Zip Phone #

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ CO-PAY \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

Your signature below provides consent to care for the individual listed in the Patient Information section. Further, your signature authorizes the medical provider to release and disclose such protected medical information necessary to process your insurance claim (if any) and to carry out healthcare operations. You consent that an outside pathology laboratory can bill you for analysis of samples taken of skin, nail, etc. You herein authorize payment of medical benefits to North Idaho Dermatology when an assigned claim is filed. Thank you.

Patient or Authorized Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_