Dermatology & Skin Care Center of West Linn

Patient Information

Full Name: _____ Date of Birth: _____

Mailing Address: _____

City, State, Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Which phone number do you prefer that we use to contact you? _____

May we leave a message at the preferred phone number with laboratory and biopsy results, appointment reminders, or other matters relating to your medical health? YES - NO

Email Address: _____

Sex: MALE - FEMALE Marital Status: SINGLE - MARRIED - OTHER

Race: AMERICAN INDIAN - ALASKA NATIVE - ASIAN - BLACK OR AFRICAN AMERICAN - HISPANIC - INDIAN - MIDDLE EASTERN - NATIVE HAWAIIAN - PACIFIC ISLANDER - PERSIAN - WHITE - I CHOOSE NOT TO SPECIFY

Ethnicity: HISPANIC OR LATINO - NOT HISPANIC OR LATINO - I CHOOSE NOT TO SPECIFY

Legal Representative (Parent, Guardian)

Full Name: _____ Relationship to Patient: _____

Mailing Address: _____

City, State, Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Mailing Address: _____

City, State, Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Primary Care or Family Physician

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Referring Physician: Were you referred to us by a physician or other healthcare provider? YES - NO

If yes, name of referring physician: _____

Preferred Pharmacy

Name of Pharmacy: _____

Address or General Location: _____

Primary Insurance Information

Insurance Company Name: _____

Name of Policy Holder: _____

Relationship of Policy Holder to Patient: SELF - SPOUSE - PARENT - OTHER: _____

Address of Policy Holder: _____

City, State, Zip Code: _____

Date of Birth of Policy Holder: _____ Phone Number: _____

Secondary Insurance Information

Insurance Company Name: _____

Name of Policy Holder: _____

Relationship of Policy Holder to Patient: SELF - SPOUSE - PARENT - OTHER: _____

Address of Policy Holder: _____

City, State, Zip Code: _____

Date of Birth of Policy Holder: _____ Phone Number: _____

Dermatology & Skin Care Center of West Linn

Patient Name: _____ Date of Birth: _____ Today's date: _____

Height: _____ Reason for your visit: _____

Past Medical History: (Please circle all that apply)

Anxiety	Coronary artery disease	IBD
Arthritis	Depression	Leukemia
Artificial joints	Diabetes	Lung cancer
Asthma	End stage renal disease	Lymphoma
Atrial fibrillation	GERD	Prostate cancer
Bleeding disorder	Hearing loss	Radiation treatment
Bone marrow transplant	Hepatitis (B, C)	Seizures
Breast cancer	HIV	Stroke
Colon cancer	Hypertension	Valve replacement
COPD	Hyper/Hypothyroidism	None

Other: _____

History of an allergic reaction to: (Please circle all that apply)

Lidocaine Epinephrine Mupirocin (Bactroban) Hibiclens Betadine

Do you have a pacemaker or a defibrillator? NO YES

Are you currently pregnant or breastfeeding? NO YES

Past Surgical History: (Please circle all that apply)

Mastectomy (right, left, bilateral)	Organ transplant (kidney, liver, heart)
Lumpectomy (right, left, bilateral)	Ovaries removed: endometriosis
Colectomy: colon cancer resection	Ovaries removed: cyst
Colectomy: diverticulitis	Ovaries removed: ovarian cancer
Colectomy: IBD	Prostate removed: prostate cancer
Coronary artery bypass	Liver biopsy
Mechanical valve replacement	Skin biopsy
Biological valve replacement	Basal cell carcinoma surgery
Hysterectomy: fibroids	Squamous cell carcinoma surgery
Hysterectomy: uterine cancer	Melanoma surgery
Joint replacement, knee (right, left, bilateral)	Atypical mole surgery
Joint replacement, hip (right, left, bilateral)	Spleen removed
Joint replacement within last 2 years	Kidney removed (right, left)
None	

Other: _____

Skin Disease History: (Please circle all that apply)

Actinic keratosis	Eczema	Psoriasis
Atypical moles	Keloids	Skin infection
Basal cell carcinoma	Melanoma	Squamous cell carcinoma
Contact dermatitis	None	

Other: _____

Do you wear sunscreen? NO YES: What SPF? _____
Have you ever tanned in a tanning salon? NO YES: How often? _____
Do you have a history of blistering sunburns? NO YES: What age? _____

Do you have family members with history of:
Melanoma? NO YES: Relationship? _____
Non-melanoma skin cancers? NO YES: Relationship? _____
Asthma? NO YES: Relationship? _____
Eczema? NO YES: Relationship? _____
Hay fever? NO YES: Relationship? _____

Other family medical history: _____

Medications: (Please enter all current medications)

_____
_____
_____

Medication Allergies: (Please enter all allergies and associated reactions)

_____
_____
_____

Social History:
Do you currently smoke? NO YES: How much? _____
Have you ever smoked? NO YES: When did you quit? _____
Do you drink alcohol? NO YES: How much? _____
What is your occupation? _____

Date of last menstrual cycle: _____

Do you currently have any of the following symptoms? (Please circle all that apply)

Fevers Night sweats/chills Weight loss Loss of appetite

Are you currently experiencing or have you previously experienced any of the following?
(Please circle all that apply)

Artificial joints within past two years
Artificial heart valves
Premedication prior to procedures
A skin reaction to adhesives
Taking blood thinners
Problems with bleeding
Problems with wound healing
Problems with scarring or keloid
Upset stomach with antibiotics
Fainting
Immunosuppression
Hay fever or seasonal allergies

Other current symptoms: _____
_____
_____

Dermatology & Skin Care Center of West Linn

Acknowledgement of Privacy Policy

The Notice of Privacy Policy of the Dermatology & Skin Care Center of West Linn describes how health information about me may be used and disclosed. The following is a summary of our Notice of Privacy Policy:

Your Rights - As examples, you have the right to:

- Get a copy of the privacy notice.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a copy of your paper or electronic medical record.
- File a complaint if you believe your privacy rights have been violated.

Your Choices - You have some choices in the way that we use and share information. With your permission, we may tell family and friends about your condition.

Our Uses and Disclosures - We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Comply with the law.
- Respond to lawsuits and legal actions.

For further details, you may obtain a full copy of our Notice of Privacy Policy. I acknowledge that I have had an opportunity to review the Notice of Privacy Policy and may obtain a copy of the Notice of Privacy Policy at will from the Dermatology & Skin Care Center of West Linn.

Please initial: _____

Consent for Release of Information

I authorize the Dermatology & Skin Care Center of West Linn to release medical information to my primary care physician, referring physician, consultants, and as necessary to process insurance claims and order prescriptions.

Please initial: _____

Consent for Treatment

I authorize medical staff of the Dermatology & Skin Care Center of West Linn to provide medical care and perform procedures (skin biopsies, routine surgical procedures, etc.). I also acknowledge that no guarantee can or will be made as to the results of the medical care or procedures.

Please initial: _____

Acknowledgement of Laboratory Practices

My tissue and culture specimens (e.g., from biopsies or swabs) will be sent to a laboratory outside of the Dermatology & Skin Care Center of West Linn for processing. The laboratory will bill me or my insurance company separately for processing of the tissue and culture specimens.

Please initial: _____

Acknowledgement of Financial Policies

I acknowledge the following:

- Payment of balances owed from prior appointments are due before a subsequent appointment or service.
- As a service to me, the staff of the Dermatology & Skin Care Center of West Linn will bill my insurance company, but I will be responsible for any charges that are not paid by my insurance company within 60 days.
- Copays, coinsurance, and deductibles required by my insurance company are due at the time of service.
- If my insurance company requires a referral or a prior authorization, then it is my responsibility to obtain the referral or prior authorization before the time of my appointment.
- If I am uninsured or have an insurance plan that is not accepted at the Dermatology & Skin Care Center of West Linn, then I will be responsible for payment in full at the time of service.
- Cosmetic procedures are not covered by my insurance company and payment for cosmetic procedures is due at the time of service.

Please initial: _____

Acknowledgement of Mobile Phone and Recording Policies

The policies of the Dermatology & Skin Care Center of West Linn restrict use of mobile phones during appointments, as well as the making of audio and video recordings (including the taking of photos) with mobile phones or other devices, unless specifically authorized by medical staff.

Please initial: _____

Consent for Assignment of Benefits

I authorize the Dermatology & Skin Care Center of West Linn to bill and collect all payments of medical benefits from my insurance company, Medicare, or other responsible payer for services or products provided by the Dermatology & Skin Care Center of West Linn.

Please initial: _____

I hereby agree to the above Acknowledgements and Consents:

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship to Patient