DERMAHEALTH
DERMATOLOGY & DERMASURGERY
The Pacific Northwest Skin Expert

1305 Fowler St., Suite 1C
Richland, WA 99352
Office: 509-783-2004
Fax: 509-783-1949

(PLEASE PRINT)

Date: _____ Home Phone: _____

Patient Information: Cell Phone: _____

Name: _____
Last Name First Name M.I.

Mailing Address: _____

City: _____ State: _____ Zip: _____ Birth Sex: M_____ F_____ Age: _____

Birth date: _____ Status: ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered

Email: _____

Race: ☐White ☐Black ☐Asian ☐American Indian ☐Pacific Islander Other: _____ Ethnicity: ☐Hispanic ☐Not Hispanic

Preferred Language: ☐ English ☐ Spanish Other: _____

How did you hear about us? _____

Name of doctor you were referred by_____

Emergency Contact: _____ Phone: _____

Is there any person (including your spouse) that you would like medical information released to? If so please give the following information:

_____ _____
Name Relationship

INSURANCE: A copy of your insurance card(s) will be taken at registration. Insurance card must be brought to the appointment along with a list of your medications and any allergies to medications.

Primary Insurance Policy Holder Information: (This is the subscriber's information)

Primary Policy Holder: _____ Sex: M_____ F _____
Last Name First Name M.I.
Relationship to Patient: _____ Policy Holder Birth date: _____

Primary Insurance Subscriber ID#: _____ Group #: _____

Phone #: _____

Secondary Insurance Policy Holder Information: (This is the subscriber's information)

Secondary Policy Holder: _____ Sex: M_____ F _____
Last Name First Name M.I.
Relationship to Patient: _____ Policy Holder Birth date: _____

Secondary Insurance Subscriber ID#: _____ Group #: _____

Phone #: _____

DERMAHEALTH
DERMATOLOGY & DERMASURGERY
The Pacific Northwest Skin Expert

1305 Fowler St., Suite 1C
Richland, WA 99352
Office: 509-783-2004
Fax: 509-783-1949

Insurance Policy

My signature below acknowledges my understanding that all services and procedures performed during this visit may be subject to deductible, co-pay, or co-insurances through my insurance. I understand that I will be fully responsible for all deductibles, co-pays and co-insurance amounts that my insurance assesses. I understand that pathology, excisions, biopsies destruction of lesions and other procedures during the course of a normal office visit are often applied to the deductible.

I certify that the insurance information I have provided is complete, true and correctly recorded to the best of my knowledge. I accept full financial responsibility if I do not disclose ALL insurance coverages.

I hereby authorize the release of any medical information required by my insurance carrier for services rendered to me in order to process claims on my behalf. I request that payments of authorized medical benefits be made to the above provider. I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered.

Signature: _____Date_____

HIPAA Patient Consent
Consent & Authorization for Treatment
Office & Financial Policy

I acknowledge the receipt of the HIPAA Notification Form, the DermaHealth Office & Financial Policy Form, and the Consent & Authorization for Treatment Form. I understand and agree to the policies, terms, and conditions set forth in them.

Patient or Legal Guardian Signature:_____

Printed Name:_____ Date:_____

DERMAHEALTH
DERMATOLOGY & DERMASURGERY
The Pacific Northwest Skin Expert

1305 Fowler St., Suite 1C
Richland, WA 99352
Office: 509-783-2004
Fax: 509-783-1949

24-Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, DermaHealth Dermatology & Dermasurgery reserves the right to charge a fee of **$50.00** for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name _____ Date _____

Signature _____

DERMAHEALTH
DERMATOLOGY & DERMASURGERY
The Pacific Northwest Skin Expert

1305 Fowler St., Suite 1C
Richland, WA 99352
Office: 509-783-2004
Fax: 509-783-1949

Name: _____ DOB: _____

Please select any of the following medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ BPH (Enlarged Prostate-men only)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer (men only)
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other Medical Conditions: _____

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Mastectomy □ left □ right □ both
- ☐ Breast: Lumpectomy □ left □ right □ both
- ☐ Breast: Breast Biopsy
- ☐ Breast: Breast Reduction
- ☐ Breast: Breast Implants
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement:_____ □ left □ right □ both
- ☐ Kidney: □Biopsy □ Nephrectomy □ Stone Removal □ Transplant
- ☐ Ovaries (Oophorectomy): □ Endometriosis □ Cyst □ Cancer
- ☐ Pancreas: pancreatectomy
- ☐ Prostate (Prostatectomy): □ Cancer □ Biopsy □ TURP
- ☐ Skin: □ Biopsy □ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Melanoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchidectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Other:_____ _____

DERMAHEALTH
DERMATOLOGY & DERMASURGERY
The Pacific Northwest Skin Expert

1305 Fowler St., Suite 1C
Richland, WA 99352
Office: 509-783-2004
Fax: 509-783-1949

Name: _____ DOB: _____

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratosis (Pre-Cancers)
- ☐ Basal Cell Skin Cancer
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other:_____
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma (Malignant Melanoma)
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

Do you wear sunscreen? □ Daily □ Sometimes □ No SPF?: _____

Do you currently or have you ever used a tanning bed? □ Current □ Past □ No

Do you have a family history of melanoma? □ No □ Yes - Relationship:_____

MAY WE CALL TO LEAVE DETAILED MESSAGES? □ Yes □ No

PRIMARY CARE DOCTOR: _____

PREFERRED PHARMACY: _____
(Please include Name and Street Location)

Please list any medications you are taking; both prescription and over the counter:

Do you take aspirin or a baby aspirin? _____ Yes _____ No

Known Drug Allergies:

DERMAHEALTH
DERMATOLOGY & DERMASURGERY
The Pacific Northwest Skin Expert

1305 Fowler St., Suite 1C
Richland, WA 99352
Office: 509-783-2004
Fax: 509-783-1949

Name: _____ DOB: _____

Do you or have you ever used any tobacco products? □ Current □ Past □ No

How often do you exercise? _____

Please select if you have the following:

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ (hypertrophic or keloid)
- ☐ Immunosuppressant
- ☐ Changing mole
- ☐ Rash
- ☐ Abdominal pain
- ☐ Anxiety
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Chest pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or chills
- ☐ Headaches
- ☐ Hay fever
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Night sweats
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Thyroid problems
- ☐ Wheezing
- ☐ Unintentional weight loss
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Daily use of blood thinners (Aspirin, Coumadin, Warfarin, Plavix, etc.)
- ☐ Artificial joints within past two years
- ☐ Artificial heart valve
- ☐ Premedication prior to procedures
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotic ointments
- ☐ Pregnancy or planning a pregnancy
- ☐ Allergy to lidocaine
- ☐ Rapid heartbeat with epinephrine
- ☐ Yeast infections with antibiotics
- ☐ GI Upsets with antibiotics

Do you have a family history of any of the following? If yes, please indicate the relationship

☐	Psoriasis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Eczema	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Sarcoidosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Lupus	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Raynaud Phenomenon	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Malignant Melanoma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Systemic Sclerosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Basal Cell Carcinoma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐	Squamous Cell Carcinoma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son