1295 Fowler St., Suite 102
Richland, WA 99352
Office: 509-783-2004
Fax: 509-783-1949

(PLEASE PRINT CLEARLY)

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: _______________________________ Employer: _______________________

How did you hear about us? ____

Name of doctor you were referred by____

Emergency Contact: ____ Phone: ___________________________________

Is there any person (maybe your spouse?) that you would like medical information released to? If so please give the following information: ***(This will remain in effect until you give written notice of a change.)***

____ ____
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 #: _______________________________________

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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

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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 **($100.00** for surgical appointments) 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 ____

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Name: ____ DOB: ______________

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

- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Cerebrovascular accident (Stroke)
- ☐ COPD
- ☐ Coronary Arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Elevated blood pressure
- ☐ End stage renal disease
- ☐ Epilepsy
- ☐ Other Medical Conditions: ____
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of prostate

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Mastectomy ☐ left ☐ right ☐ both
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colostomy)
- ☐ 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:
  - ☐ Nephrectomy
  - ☐ Transplant
- ☐ Ovaries (Oophorectomy)
- ☐ Pancreas: pancreatectomy
- ☐ Prostate (Prostatectomy)
- ☐ Skin:
  - ☐ Basal Cell Carcinoma
  - ☐ Squamous Cell Carcinoma
  - ☐ Melanoma
- ☐ Testicles (Orchidectomy)
- ☐ Uterus (Hysterectomy)
- ☐ Other:__________________________ ______________________________

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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
- ☐ Second Degree Sunburn

Do you wear sunscreen? ☐ Daily ☐ Sometimes ☐ No SPF?: ____________
Do you currently use, 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

Email: ____

PRIMARY CARE DOCTOR: ____

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

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

1.	4.
2.	5.
3.	6.

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

Known Drug Allergies:

1.	2.

Do you use, or have you ever used, any tobacco products? ☐ Current ☐ Past ☐ No

For patients 65 and older:

- Have you ever received a pneumonia vaccination? ☐ Yes ☐ No
- Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
- Do you have a living will? ☐ Yes ☐ No

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Name: ____ DOB: ________________

Please select if you have the following:

- ☐ Rash
- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ (hypertrophic or keloid)
- ☐ Immunosuppressant
- ☐ Changing mole
- ☐ 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