



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: _____ Employer: _____

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: (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 #: _____



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: _____



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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 _____



Name: _____ DOB: _____

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

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

Have you had any surgeries on the following organs?

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



Name: _____ DOB: _____

Have you had any of the following skin conditions?

- | | |
|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaking or Itchy Scalp |
| <input type="checkbox"/> Actinic Keratosis (Pre-Cancers) | <input type="checkbox"/> Melanoma (Malignant Melanoma) |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Other: _____ | |

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



Name: _____ DOB: _____

Please select if you have the following:

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

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

<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Eczema	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Sarcoidosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Lupus	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Raynaud Phenomenon	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Malignant Melanoma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Systemic Sclerosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Basal Cell Carcinoma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> Squamous Cell Carcinoma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son