Valley Dermatology
& SKIN CANCER CENTER

13512 E. Mansfield Ave
Spokane Valley, WA 99216
P: 509-892-2480 **F**: 509-892-6708

Name: _____ Date of Birth: _____

(Last) (First) (Middle Initial)

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Social Security #: _____-_____-_____

Email Address: _____ Occupation: _____

Preferred Language: (Circle) English Spanish Other: _____
Ethnicity: (Circle) Hispanic or Latino Non-Hispanic or Latino Other: _____
Race: (Circle) White American Indian or Native Alaskan Asian Black or African American
Native Hawaiian or Pacific Islander Other: _____

Preferred Pharmacy (Name & Location) _____

Primary Care Physician's Name/Clinic _____

Emergency Contact: _____ **Phone**: _____-_____-_____ **Relationship**: _____

Reason for Visit? _____
How long has this been a problem? _____
Have you tried anything prescription or over the counter?_____
If so, what and how long? _____
Any history of joint pain? _____
Any history of systemic problems? _____

Past Medical History: (Please check all that apply)

- o Anxiety
- o Arthritis
- o Artificial joints
- o Asthma
- o Atrial Fibrillation
- o Autoimmune Disease (List) _____
- o BPH
- o Bone Marrow Transplantation
- o Breast Cancer
- o Colon Cancer
- o COPD
- o Coronary Artery Disease
- o Depression
- o Diabetes
- o End State Renal Disease
- o GERD
- o Hearing Loss
- o Hepatitis
- o Hypertension
- o HIV/AIDS
- o Hypercholesterolemia
- o Hyperthyroidism
- o Hypothyroidism
- o Leukemia
- o Lung Cancer
- o Lymphoma
- o Neurological Illness (Myasthenia Gravis)
- o Pacemaker
- o Prostate Cancer
- o Radiation Treatment
- o Seizures
- o Stroke
- o Valve Replacement
- o Other: _____

Past Surgical History: (Please check all that apply)

- o Basal Cell Cancer Surgery
- o Breast Biopsy (R/L/B)
- o Heart: Coronary Artery Bypass
- o Heart: Valve Replacement
- o Joint Replacement: Hip (R/L/B)
- o Joint Replacement Within Past 2 Years
- o Joint Replacement: Knee (R/L/B)
- o Kidney Removed (R/L)
- o Lumpectomy (R/L/B)
- o Mastectomy (R/L/B)
- o Melanoma Surgery
- o Skin Biopsy
- o Spleen Removed
- o Squamous Cell Cancer Surgery
- o Other: _____

Skin Disease History: (Please check all that apply)

- o Acne
- o Actinic Keratosis
- o Basal Cell Skin Cancer
- o Blistering Sunburns
- o Cold Sores
- o Dry Skin
- o Eczema
- o Flaking or Itchy Scalp
- o Hay Fever/Allergies
- o Melanoma
- o Precancerous Moles
- o Psoriasis
- o Squamous Cell Skin Cancer
- o Other: _____

Do you wear sunscreen? YES/NO
What SPF: _____
Do you tan in a tanning salon? YES/NO

Do you have a family history of melanoma? YES/NO
Who: _____
Any other family history of skin cancer? _____

Medications: (Please list names of all current medications, dosage, and frequency)

_____

Allergies: (Please list all allergies with reaction)

_____

History of Smoking? (Circle) Never Smoked Former Smoker Smokes Daily
History of Alcohol Use? (Circle) 0-1 drink per day 2+ drinks per day

Have You Ever Had the Pneumonia Shot? YES/NO
Flu Shot? YES/NO
Shingles? YES/NO

Healthcare Proxy? YES/NO Name: _____
Living Will? YES/NO
Preference of *Intubation* or *Do Not Resuscitate*?

Current Problems With: (Please check all that apply)

- o Abdominal Pain
- o Anxiety/Depression
- o Bloody Stool/Bloody Urine
- o Blurry Vision
- o Chest Pain
- o Cough
- o Fever or Chills
- o Hay Fever
- o Headaches
- o Immunosuppression
- o Joint Aches
- o Muscle Weakness
- o Neck Stiffness
- o Night Sweats
- o Problems with bleeding
- o Problems with healing
- o Problems with scarring
- o Seizures
- o Shortness of breath
- o Sore Throat
- o Thyroid Problems
- o Unintentional weight loss
- o Wheezing

Alerts: (Please check all that apply)

- o Allergy to Adhesive
- o Allergy to Latex
- o Allergy to Lidocaine
- o Allergy to topical antibiotic ointment
- o Artificial joints within past 2 years
- o Artificial or damaged heart valve
- o Blood thinners
- o Defibrillator
- o Pacemaker
- o Pregnant or planning a pregnancy
- o Premedication prior to procedures
- o Rapid heartbeat with epinephrine

Cosmetic Concerns: (Optional)

- o Acne/Acne Scarring
- o Brown Spots/Sun Damage
- o Spider Veins
- o Fine Lines & Wrinkles
- o Dry Skin
- o Large Pores/Blackheads
- o Looking Tired
- o Double Chin/Jowls

Would you like us to schedule you a complimentary cosmetic consultation? _____

To cancel an appointment, we require notification at least 24 hours in advance.
You can contact our office @ 509-892-2480, and always feel free to leave a voicemail if calling after hours.

Signature: _____ **Date**: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES STATEMENT

To our valued patients,

The privacy of your health care information is extremely important to Valley Dermatology and Skin Cancer Center. Please review our Privacy Practices Statement that describes our legal duties with respect to your health care information.

We use private personal information to:

- Provide treatment to you,
- Ensure appropriate payment for the treatment we provide
- Monitor the quality of our operations

Under certain cases we are permitted to disclose health care information about you. This disclosure includes when there is a serious threat to health or safety, to reduce public health risks, for health oversight, as required by law to the Federal Government or for law enforcement.

You have the right to view and receive a copy of your protected health information. You also have the right to request a restriction on the use or release of your information. While we make every effort to honor such requests, certain circumstances could prevent us from restricting access.

You have the right to receive confidential communications about your care or treatment. This copy of our Privacy Practices Statements is available upon request.

We are required by law and professional codes of ethics to safeguard the privacy of your protected health information and provide you with this legal notice of our duties and privacy practices. We will make every effort to comply with the terms of the Privacy Practices Statement now in effect.

Please sign below that you have received and read Valley Dermatology and Skin Cancer Center's Privacy Practice Statement. If you have any questions, please speak to your provider or our Practice Manager, Stephanie Cherrstrom at (509) 892-2480.

I, _____, authorize Valley Dermatology & Skin Cancer Center
(Print Name)
to release my medical information to _____ or leave a message at _____
(Family Member) optional (Phone number)

Signature: _____ **Date**: _____

Insurance Information				
Primary Insurance:		ID #		Group #
Name of Subscriber:	SS #	Birth date:	Sex M ☐ F ☐	Relationship to Subscriber Self ☐ Spouse ☐ Child ☐ Other
Secondary Insurance:		ID#		Group#
Name of Subscriber:	SS #	Birth date:	Sex M ☐ F ☐	Relationship to Subscriber Self ☐ Spouse ☐ Child ☐ Other

It is your responsibility to know if the provider you are seeing is contracted with your insurance, whether your insurance requires an authorization, as well as your plans specific coverage and benefits.
Initial: _____ *Date:* _____

Please read and sign in order to bill your insurance:
Necessary forms will be completed to help expedite insurance carrier payments.

I hereby authorize Valley Dermatology and Skin Cancer Center to release any and all medical information to the above-named insurance carrier. This remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy. I hereby assign to Valley Dermatology and Skin Cancer Center, all money to which I am entitled for medical and/or surgical expenses relative to the services rendered. I understand I am financially responsible to Valley Dermatology and Skin Cancer Center for the charges not covered by insurance. I further agree in the event of non-payment to bear the cost of collection, and/or court cost and reasonable legal fees should this be required. Additionally, if I am covered by Medicare, I request that payment of authorized Medicare benefits be made on my behalf to Valley Dermatology and Skin Cancer Center for any services I receive. I authorize my information to be released to Center for Medicare/Medicaid services, to determine these benefits payable for related services until rescinded.

Signature: _____ **Date:** _____

(If Patient Is A Minor)
Guarantor/Giving Consent To Treat:

Name: _____ Date of Birth: _____
Relationship to Patient:_____ Phone: _____-_____-_____