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: ______________ Sex: M / F

(Last) (First) (Middle Initial)

Mailing Address: _________________________________ City: __________ State: _____ Zip Code: _______

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

Email Address: ___________________________________ Occupation: __________ Employer Phone: __________
Employer Name: _______________________ Employer Address: ____

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: ____

Primary Care Physician's Name/Clinic _______________________ **Pharmacy (Name & Location)** __________________

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) *Month/Year* _______
- o Joint Replacement: Knee (R/L/B) *Month/Year* _______
- 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)

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

Do you wear sunscreen? YES/NO
Do you tan in a tanning salon? YES/NO

Do you have a family history of melanoma? YES/NO
Who: _______________

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)

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

Alerts: (Please check all that apply)

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

Cosmetic Concerns: (Optional)

- Acne/Acne Scarring
- Brown Spots/Sun Damage
- Spider Veins
- Fine Lines & Wrinkles
- Dry Skin
- Large Pores/Blackheads
- Looking Tired
- 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**: ___________________________________

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

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:** ____________________

<u>(If Patient Is A Minor)</u>

Guarantor/Giving Consent To Treat:

Name: ____ Date of Birth: ______________________

Relationship to Patient:____ Phone: ________-________-________