ValleyView DERMATOLOGY

Thank you very much for choosing Valley View Dermatology to provide you the best in dermatology care!

Please complete the enclosed registration and patient information forms, and either mail them to us ahead of time, or bring them into your New Patient visit with our office. Also, please bring your current insurance cards and a photo identification. As a courtesy to our patients, we bill all primary and secondary insurances with whom we are contracted.

Co-payments and/or deductibles are required to be paid at the time of service.

As a courtesy, if your insurance requires one, Valley View Dermatology will attempt to get a prior-authorization or referral on your behalf. We still request that you contact your primary care provide for a referral, as that will assist us in caring for you.

You will receive several reminders for your appointment. If for some reason, you need to cancel or reschedule your appointment, please call our appointment line at 971-374-2150 at least 48 hours prior to your appointment time.

If you have any other questions regarding our providers, your appointment, or your insurance, please contact our office at 503-364-3321.

Valley View Dermatology

_____ has an appointment scheduled on

_____ at _____

(PLEASE ARRIVE 10 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME)

❑ **SALEM**
2441 Grear St. NE
Salem, OR 97301
503-364-3321

❑ **SOUTH SALEM**
2521 Boone Rd. SE, Ste 140
Salem, OR 97306
503-364-3321

❑ **KEIZER**
(Located upstairs in Salem Clinic)
5900 Inland Shores Way, Ste 201 202
Keizer, OR 97303
503-364-3321

❑ **WILSONVILLE**
8840 SW Citizens Dr.
Wilsonville, OR 97070
503-364-3321

❑ **LINCOLN CITY**
3015 W Devil's Lake Road
Lincoln City, OR 97367
503-364-3321

❑ Michael E. Goodenberger, MD
❑ Shashi K. Srinivasan, MD
❑ Preston W. Chadwick, MD
❑ Erik W. J. Kokkonen, MD
❑ Samuel F. Bremmer, MD
❑ Reyna D. Swift, MD
❑ Gabriel P. Currie, MD
❑ Ivy I. Norris, MD
❑ Amy Ullan, PA-C
❑ Teresa George, PA-C
❑ Eric B. Harmon, PA-C
❑ Kara A. Arnold, PA-C
❑ Jason Ludlow, PA-C

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PATIENT INFORMATION

Name: _____ Identify as: Male ❑ Female ❑ Other ❑

Mailing Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Email: _____

Cell Phone: _____ Date of Birth: _____

Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow ❑ Other ❑

Personal Identity: He/Him/His ❑ She/Her/Hers ❑ They/Them/Their ❑

Required Information: Preferred Language _____ **Ethnic Group** _____

Employer Name: _____ Phone: _____

Employment Status: Full ❑ Part ❑ Retired ❑ None ❑ Student ❑

Referred by Dr. _____ **Primary Care Physician:** _____

Medical Insurance: _____ ID #: _____

What provider are you seeing?

- ❑ Michael E. Goodenberger, MD
- ❑ Shashi K. Srinivasan, MD
- ❑ Preston W. Chadwick, MD
- ❑ Erik W. J. Kokkonen, MD
- ❑ Samuel F. Bremmer, MD
- ❑ Reyna D. Swift, MD
- ❑ Gabriel P. Currie, MD
- ❑ Ivy I. Norris, MD
- ❑ Amy Ullan, PA-C
- ❑ Teresa George, PA-C
- ❑ Eric B. Harmon, PA-C
- ❑ Kara A. Arnold, PA-C
- ❑ Jason Ludlow, PA-C

Emergency Contact _____ Relationship _____ Phone _____

ALL PATIENTS PLEASE READ AND SIGN THE STATEMENT BELOW

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. THIS INCLUDES CO-PAYMENTS AND DEDUCTIBLES. We accept VISA, Mastercard, Discover, and American Express for your convenience. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance/ Medicare claims (if any). You herein authorize payment of medical benefits to the Doctor when assigned claim is filed.

_____ _____

Signature of patient or legal guardian Date

PLEASE PRESENT YOUR INSURANCE CARDS AND PHOTO IDENTIFICATION TO THE RECEPTIONIST. THE RECEPTIONIST WILL MAKE A COPY AND RETURN THEM TO YOU PROMPTLY. vvd PI 05/2023

ValleyView DERMATOLOGY

Patient Policies

Name:_____ **Account Number:**_____ **Date:**_____

At Valley View Dermatology we are committed to building a successful and long-term provider-patient relationship with you and your family. Your clear understanding of our patient related policies is an integral part of its professional relationship. Please feel free to ask if you have any questions regarding our policies.

Financial Policy

Initials of Patient or Responsible Party

It is the patient's responsibility to provide updated insurance information, current address, and contact information. Failure to provide up-to-date insurance information may lead to any visit balances being the patients responsibility. Payment for the estimated portion of the patient's financial responsibility, including co-pays and deductibles is expected at the time services are provided.

As a courtesy to our patients we bill all major insurance companies, including Medicare and Medicaid. However, your health insurance coverage is a contract between the patient and an insurance company, and it is the patient's responsibility to know the details of coverage under their insurance plan. Some insurance companies require referrals or authorizations for some services. As a courtesy, our office will attempt to get needed referral and/or authorization, however, it is ultimately the patient's responsibility to acquire these, and failure to do so may result in any visit balance being the patient's responsibility.
If you have questions regarding your visit, or any post-visit balance, please contact our business office at 503-588-0469.

We at Valley View Dermatology understand that there are times when patients cannot make their scheduled appointments. We request that when those times occur, that you give us at least 48 hours notice prior to your scheduled appointment. Failure to cancel your appointment in a timely fashion, or no-show for an appointment may result in a charge of $125.00 for the office visit or 300.00 for MOHS.

_____
Initials

Assignment of Benefits

I authorize and assign my insurance company, including Medicare or Medicaid, to directly pay benefits for services to Valley View Dermatology for any services provided to me. Further, I authorize Valley View Dermatology to release to my insurance company, including Medicare or Medicaid, any pertinent medical information regarding the services provided to me for the purpose of determining benefits.

_____
Initials

Notice of Privacy Practices

_____
Initials

I acknowledge that I have been offered and/or have received the Notice of Privacy Practices for Valley View Dermatology.

Release of Medical Information

Please check appropriate box

I authorize the following means of communication:

- ☐ Yes ☐ No Leave a message on my home/cell voicemail
- ☐ Yes ☐ No Contact me at my work
- ☐ Yes ☐ No Leave a message on my work voice mail
- ☐ Yes ☐ No Speak to or discuss your medical condition with anyone else in your household:

  If yes, whom:_____ relationship:_____ phone:_____

_____ _____
Signature of Patient or Responsible Party **Date**

ValleyView DERMATOLOGY

Patient Name: _____ DOB: _____ Phone #: _____

NEW PATIENT MEDICAL HISTORY

Please print legibly

PAST MEDICAL HISTORY *(Please check all that apply)*

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation (Irregular Heartbeat)
- ❑ Cancer
  - If you have had cancer, what type: _____
- ❑ Clotting disorder / Deep Vein Thrombosis (DVT) / Phlebitis
- ❑ Coronary Artery Disease (CAD)
- ❑ Depression
- ❑ Diabetes
- ❑ GERD (Acid Reflux)
- ❑ Hepatitis A ____ B ____ C ____
- ❑ High Blood Pressure / Hypertension
- ❑ High Cholesterol
- ❑ Thyroid Disorder, what type: _____
- ❑ Seizures
- ❑ Stroke
- ❑ Kidney Disease
- ❑ Valvular Heart Disease / Valve Surgery / Valve Replacement
- ❑ Other _____
- ❑ None of the above

PAST SURGICAL HISTORY *(Please check all that apply)*

- ❑ Heart Coronary Artery Bypass
- ❑ Joint Replacement
  - Knee: ❑ Right ❑ Left ❑ Bilateral
- ❑ Joint Replacement
  - Hip: ❑ Right ❑ Left ❑ Bilateral
- ❑ Kidney Transplant
- ❑ Skin Biopsy
- ❑ Basal Cell Carcinoma Surgery
- ❑ Squamous Cell Carcinoma Surgery
- ❑ Melanoma Surgery
- ❑ Other Organ Transplant – Type: _____
- ❑ Other _____
- ❑ None of the above

SKIN DISEASE HISTORY *(Please check all that apply)*

- ❑ Acne
- ❑ Actinic Keratosis
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Cold Sores / Fever Blisters
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking / Itchy Scalp
- ❑ Hay Fever / Allergies
- ❑ Melanoma
- ❑ Poison Oak
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Rash with Medications
- ❑ Squamous Cell Skin Cancer
- ❑ Other _____

COSMETIC QUESTIONNAIRE *(Please check all that apply)*

Please mark areas you are interested in discussing

- ❑ Significant lines around nose & mouth
- ❑ Frown lines between brows
- ❑ Fine lines and wrinkles
- ❑ Lash length or thickness
- ❑ Crow's feet
- ❑ Sagging skin
- ❑ Freckles or age spots
- ❑ Hyperpigmentation
- ❑ Facial hair
- ❑ Adult acne
- ❑ Other, please specify _____

_____

❑ Yes ❑ No Do you wear SUNSCREEN?
If yes, what SPF: _____

❑ Yes ❑ No Have you had a history of longtime exposure?

❑ Yes ❑ No Do you burn easily?

What is your occupation? _____

FAMILY HISTORY *(Please answer YES or NO)*

❑ Yes ❑ No Do you have a family history of skin cancer?
If yes, which relative? _____
If yes, what kind of skin cancer? ❑ Basal Cell Carcinoma ❑ Squamous Cell Carcinoma ❑ Melanoma ❑ Unknown

❑ Yes ❑ No Do you have a family history of psoriasis?

❑ Yes ❑ No Do you have a family history of atopic dermatitis/eczema?

OVER →

SOCIAL HISTORY *(Please check all that apply)*

Alcohol Use

- ❑ None
- ❑ Less than 1 drink a day
- ❑ 1-2 drinks a day
- ❑ 3 or more drinks a day

Cigarette Use

- ❑ Never smoked
- ❑ Quit/former smoker
- ❑ Smoke less than daily
- ❑ Smoke daily

REVIEW OF SYSTEMS *(Please check all that apply)*

Within the last 3 months, have you experienced any of the following?

- ❑ Changing moles
- ❑ Rash
- ❑ Problems with scarring (hypertrophic or keloid)
- ❑ Problems with healing
- ❑ Problems with bleeding
- ❑ Night sweats
- ❑ Fever of chills
- ❑ Unintentional weight loss
- ❑ Immunosuppression
- ❑ Hay fever
- ❑ Anxiety
- ❑ Depression
- ❑ Chest pain
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Blurry vision
- ❑ Sore throat
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Headaches
- ❑ Seizures
- ❑ Joint aches
- ❑ Muscle weakness
- ❑ Neck stiffness
- ❑ Bloody urine
- ❑ Diarrhea
- ❑ Breast tenderness
- ❑ Menstrual irregularities
- ❑ Dizziness
- ❑ Tinnitus
- ❑ Hearing loss
- ❑ None of the above

ALERTS *(Please answer YES or NO)*

- ❑ Yes ❑ No Allergy to adhesive
- ❑ Yes ❑ No Allergy to lidocaine
- ❑ Yes ❑ No Allergy to oral antibiotic *(see allergy list)*
- ❑ Yes ❑ No Allergy to topical antibiotic ointments
- ❑ Yes ❑ No Artificial Heart Valve
- ❑ Yes ❑ No Blood thinners
- ❑ Yes ❑ No Defibrillator
- ❑ Yes ❑ No GI upset with antibiotics
- ❑ Yes ❑ No Hepatitis C
- ❑ Yes ❑ No HIV / Aids
- ❑ Yes ❑ No Latex allergy
- ❑ Yes ❑ No MRSA
- ❑ Yes ❑ No Pacemaker
- ❑ Yes ❑ No Pregnancy / planning pregnancy
- ❑ Yes ❑ No Premedications prior to procedures
- ❑ Yes ❑ No Rapid heartbeat with epinephrine
- ❑ Yes ❑ No Yeast infections with antibiotics
- ❑ None of the above

List all: Allergies	Current Over-the-counter Meds	Current Prescription Meds

ADVANCE DIRECTIVE

(Please answer YES or NO)

❑ Yes ❑ No Resuscitate

PHARMACY LOCATION

Patient / Guardian Signature: _____ Date: _____