ValleyView DERMATOLOGY

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.

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 _____

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?

SOCIAL HISTORY *(Please check all that apply)*

Alcohol Use	Cigarette Use
☐ None	☐ Never smoked
☐ Less than 1 drink a day	☐ Quit/former smoker
☐ 1-2 drinks a day	☐ Smoke less than daily
☐ 3 or more drinks a day	☐ Smoke daily

OVER →

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: _____ _____

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 225.00 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

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

_____
Initials

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**

Valley View DERMATOLOGY

IF THE PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE THIS SECTION:

Name: ______________________________ Date of Birth: ______________

Legal Guardian / Parent Name: ______________________________

Relationship to Patient: ______________________________

Legal Guardian Date of Birth: ______________________________

Address, if different from Patient: ______________________________

City: ______________________ State: ________ Zip Code: ____________

Phone Number: ______________________________

Employer: ______________________________

Employer Phone Number: ______________________________

* *

LEGAL GUARDIAN / PARENTS CONTINUE IF PATIENT IS NOT 15 YEARS OF AGE OR OLDER.

PATIENT CONTINUE IF YOU ARE 15 YEARS OF AGE OR OLDER, YOU WILL COMPLETE THE FOLLOWING:

Does Valley View Dermatology Clinic have your permission to:

☐ Yes ☐ No Leave a message on your voice mail / answering machine?

☐ Yes ☐ No May we contact you at work?

☐ Yes ☐ No May we discuss your medical condition with other members of your household?

If yes, please give the name of that person: ______________________________

What is the person's relationship to you? ______________________ Phone: ____________

______________________________ ____________
Signature of Patient (if 15 years of age or older) Date

______________________________ ____________
Signature of Legal Guardian / Parent (if younger that 15 years old) Date

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