Northwest Dermatology & Laser Clinic PC

1130 NW 22nd Avenue, Suite 330 Portland, OR 97221 503-295-2366 FAX: 503-295-3065

Patient Information (please print) Date:_____

Referred by:_____ Primary care:_____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone:_____ Sex: ◯ M ◯ F

Date of Birth: _____ Age:_____ Patient e-mail address:_____

Ethnicity:_____ (Hispanic, Non-Hispanic, Unknown) Race:_____ Primary Language_____

Patient Employer: _____ Work phone: _____

Address:_____Soc Sec #_____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed

Spouse name:_____ Spouse phone: _____

Emergency Contact: _____ Relationship_____ Phone:_____

Primary Insurance

Insurance Name: _____ Co-payment: $_____

Policy Holder/Subscriber Name:_____ Relationship:_____

ID No:_____ Group or Plan No:_____

ATTACH COPY OF CARD

Secondary Insurance

Insurance Name: _____ Co-payment: $_____

Policy Holder/Subscriber Name:_____ Relationship:_____

ID No:_____ Group or Plan No:_____

ATTACH COPY OF CARD

Responsible Party Person responsible for payment: (circle) ◯Self ◯Spouse◯Father ◯Mother ◯Other

Name: _____ DOB:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Resp Party Employer: _____ Work phone: _____

Address:_____

Pharmacy

Name:_____

Phone:_____

Email address:_____

If available, send billing statement via email? ◯Yes ◯No

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Last Name **First Name** **Middle Initial** **Date of Birth**

Pharmacy Name **Location / Phone #** **City**

Primary Care/Referring Doctor: _____

Past Medical History (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints (location)_____
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Cancer_____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ **NONE**

Other_____

Past Surgical History (please check all that apply)

- ☐ Heart Surgery
- ☐ Joint Replacement: _____
- ☐ Organ Transplant
- ☐ **NONE**

Other Past Surgical History:_____

Skin Disease History (please check all that apply)

- ☑ Acne
- ☑ Actinic Keratoses (precancerous spots)
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other:_____
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Skin Biopsy
- ☐ **NONE**

Do you wear Sunscreen? ◯ **Yes** ◯ **No**
Do you tan in a tanning salon? ◯ **Yes** ◯ **No**
Do you: ◯ **Tan easily** ◯ **Burn, then tan** ◯ **Burn easily**
Have you ever had a severe/blistering sunburn? ◯ **Yes** Age_____ ◯ **No**
Where did you grow up? _____

Do you have a family history of Melanoma? ○ **Yes** ○ **No**
If yes, which relative(s)? _____

Medications (Please enter names of all current medications) Attach sheet if necessary

Allergic to any Medications

☐ No Known Allergies:

☐ Antibiotics:

☐ Topical Substances:

☐ Other:

Smoking History (check one)

○ Never Smoked
○ Quit: former smoker
○ Smokes less than daily
○ Smokes daily

REVIEW OF SYSTEMS: (Please check Yes or No for the following)

SYMPTOMS	YES	NO
Problems with bleeding	○	○
Problems with scarring (keloid)	○	○
Immunosuppression	○	○
Changing mole	○	○
Rash	○	○
Hay fever/asthma	○	○
Abdominal Pain	○	○
Anxiety with procedures	○	○
Fever/Chills	○	○
Headaches	○	○
Joint aches	○	○
Thyroid Problems	○	○

Other Symptoms**: _____**

Preferred Language: _____

Race: _____ **Ethnic Group:_____**

ALERTS: (Please check Yes or No for the following)

SYMPTOMS	YES	NO
Allergy to adhesive	○	○
Allergy to lidocaine	○	○
Allergy to latex	○	○
Allergy to topical antibiotics	○	○
Artificial heart valve	○	○
Artificial joint replacement	○	○
Blood thinners	○	○
Defibrillator	○	○
MRSA (history of resistant staph infection)	○	○
Pacemaker	○	○
Require antibiotics prior to surgical procedure	○	○
Rapid heart beat with epinephrine	○	○
Are you pregnant or currently trying to get pregnant?	○	○

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Northwest Dermatology & Laser Clinic PC (hereinafter "clinic") as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing. Payments not made as required may be considered for collection assignment.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks
  - Charge for missed appointments without 24 hours notice

Patient Authorization

- By my signature below, I hereby authorize clinic and the physicians, staff and hospitals associated with clinic to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
- I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care.
  By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:

  ☐ Record of alcohol and/or drug abuse.
  ☐ Record of HIV (AIDS) result, diagnosis, and/or treatment.
  ☐ Record of psychiatric and/or psychological condition
- By my signature below, I hereby authorize assignment of financial benefits directly to clinic and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize clinic personnel to communication by mail, phone, and/or voice mail message, according to the information I have provided below:

Please read and then choose YES or NO:

- If you are unavailable, may we leave medical information from clinic office, such as normal blood test results or normal biopsy reports on your voice mail or with someone at your residence?
  ◯ YES – you may leave information as above
  ◯ NO – do not leave any information with anyone

If yes, please list name and relationship of person(s) we are authorized to discuss your medical care and/or account:

_____	_____	_____	_____
Name	Relationship	Name	Relationship

Northwest Dermatology & Laser Clinic PC is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

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PATIENT PRIVACY

Effective Date: 04/01/2003

We are required by law to protect the privacy of your medical information and to provide you with written Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact the office manager of our office at 503-295-2366.

Signature of Patient or Guardian Date

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Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to decline to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants.

In anonymous research, personal information that could be used to identify you, like your name or social security number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, **check the allow box**. If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

If you want to decline to have your health information and biological sample available for anonymous or coded genetic research, **check the decline box**.

Your decision is effective on the date your health care provider receives this form.

If you have any questions or concerns about this notice, please contact Patricia Keever at 503.295.2366.

No matter what you decide now, you can always change your mind later. If you change your mind, tell your health care provider your decision in writing. If you change your mind, the new decision will apply to health information or biological samples collected **after your health care provider receives written notice of your decision**.

☐ I **allow** my health information and biological samples to be available for anonymous or coded genetic research

☐ I **decline** to have my health information and biological samples available for anonymous or coded genetic research

Printed Name Signature Date