Patient Registration

PACIFIC DERMATOLOGY & COSMETIC CENTER

Patient _____ Today's Date _____
Last Name First Name MI

Address _____
Street City State Zip

Date of Birth _____ Age_____ Social Security # _____ Home Phone (_____)_____

Work Phone (_____)_____

Employer_____ Cell Phone (_____)_____

Occupation _____ Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Widowed ☐ Divorced ☐ Life Partner

How did you hear about us? _____

In order to better assess medical risks and benefits, we need to ask how you identify your race and ethnicity.

Would you like to provide that information? ☐ African American ☐ Asian ☐ White ☐ Hawaiian ☐ Native American ☐ No Response

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ No Response

Patient Provider Information

Your primary care (family) physician (PCP) _____ Phone (____)_____

Provider who referred you (if any) _____ Phone (____)_____

Please have a copy of your insurance cards and driver's license or photo ID to verify your signature and date of birth

Patient Insurance Information

First Insurance _____ Relationship to primary holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Second Insurance _____ Relationship to secondary holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of insured if not self _____ Social Security # _____ D.O.B _____
First Name Last Name

Address of insured if not self _____ (_____)_____
Street City State Zip

****For Dependants/Students person responsible for bill_____**

Emergency Contact Information

In case of an emergency, friend or relative to be notified Name_____

Relationship _____ Home Phone (_____)_____ Work Phone (_____)_____

May we contact you about upcoming or missed appointments? ☐ Yes ☐ No Best phone # (_____)_____

Would you be interested in receiving emails on any upcoming cosmetic promotions and specials? If yes, please provide us with your

Email address_____

Assignment of Benefits and Information Release Authorization

Assignment and Release: I authorize my insurance and government benefits to be paid directly to the physician. I authorize the release of medical information to my primary care physician, referring physician and medical consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Patient Signature_____

11011 Meridian Ave N, Suite 102, Seattle, WA 98133 Phone: 206-859-5777 Fax: 206-859-5776
350 S 38th Court, Suite 115, Renton, WA 98055 Phone 425-970-4155 Fax 425-970-4565

PACIFIC DERMATOLOGY & COSMETIC CENTER

PATIENT HEALTH HISTORY (PAGE 1)

Patient Name_____ Birth Date_____/_____/_____ Today's Date____/_____/_____

Are you presently or frequently bothered by any of the following symptoms? Please check any that apply. Feel free to add chronic symptoms that aren't listed that you feel are important and/or a concern to you.

GENERAL ☐ None
☐ Unexplained fever
☐ Unexplained weight loss or gain
☐ Night sweats
☐ Severe intolerance to hot or cold weather
☐ Excessive thirst

EYES, EARS, NOSE, THROAT ☐ None
☐ Double or blurred vision
☐ Ear or hearing trouble
☐ Ringing in ears/head noise
☐ Frequent nose trouble
☐ Sore mouth or throat
☐ Difficulty swallowing

HEART - CIRCULATION ☐ None
☐ Chest pain
☐ Heart palpitations
☐ Leg vein trouble
☐ Ankle swelling

LUNGS - RESPIRATORY ☐ None
☐ Shortness of breath
☐ Chest pain with breathing
☐ Wheezing
☐ Daily cough
☐ Coughing blood

GENITOURINARY ☐ None

MALE
☐ Difficulty urinating
☐ Frequent urination
☐ Discharge from penis

FEMALE
☐ Frequent urinary tract infections
☐ Frequent yeast infections
☐ Unusual bleeding or discharge from vagina
☐ Pain with urinating

GASTROINTESTINAL ☐ None
☐ Diarrhea
☐ Blood in stool
☐ Frequent heartburn
☐ Bowel problems

BONES, JOINTS, MUSCLES ☐ None
☐ Joint pain or swelling
☐ Muscle pain or severe lack of strength

NEUROLOGIC ☐ None
☐ Dizziness
☐ Headache
☐ Numbness (body parts "go to sleep")
☐ Frequent loss of balance
☐ Tremor (shaking, trembling)
☐ Convulsions (seizures, fits, epilepsy)
☐ Memory problems

MOOD - PSYCHIATRIC ☐ None
☐ Depression (feeling blue)
☐ Stress or excessive worry
☐ Trouble getting along with people
☐ Sleep disturbance
☐ Hallucinations

ALLERGY/IMMUNOLOGY ☐ None
☐ Sneezing
☐ Red/itchy eyes

HEMATOLOGIC/LYMPHATIC ☐ None
☐ Bleeding easily
☐ Bruising easily
☐ Lymph node swelling

OTHER SYMPTOMS NOT LISTED ABOVE:

_____

_____

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PATIENT HEALTH HISTORY (PAGE 2)

MEDICATIONS ☐No Medications

Please list all prescribed and over-the-counter medications you are presently taking:

_____

_____

_____

_____

ALLERGIES ☐No Allergies

Please list all allergies to medications and other substances:_____

_____

_____

SURGERIES ☐ No Surgeries

Have you had surgery on any of the following organs?

☐ Heart ☐ Lungs ☐ Intestine/Stomach

☐ Appendix ☐ Joints ☐ Bones

☐ Cancer ☐ Ovaries ☐ Hysterectomy

☐ Prostate ☐ Other_____

DO YOU HAVE ANY OF THE FOLLOWING?

Yes	No	
☐	☐	Cardiac pacemaker or defibrillator
☐	☐	Take antibiotics for dentist
☐	☐	Artificial joint or heart valves
☐	☐	HIV+ or AIDS
☐	☐	Hepatitis B or C (if yes, which_____)
☐	☐	History of severe bleeding (nose, surgical)

PAST MEDICAL HISTORY (SELF, FAMILY)

Have you or any family members had any of the following?

Self	Family	
☐	☐	Cancer (type)_____
☐	☐	Thyroid disease
☐	☐	High blood pressure
☐	☐	Diabetes
☐	☐	Tuberculosis (TB)
☐	☐	Heart disease, heart attack
☐	☐	Blood vessel disease
☐	☐	Blood clots
☐	☐	Other medical problem not listed above:

SKIN HISTORY Have you had any of the following?

Yes	No	
☐	☐	Personal history of skin cancer
☐	☐	Family history of skin cancer

If yes, what type: ☐ basal cell carcinoma
☐ squamous cell carcinoma
☐ melanoma
☐ unknown

☐	☐	Difficulty with wound healing
☐	☐	Abnormal scarring
☐	☐	Blistering sunburn
☐	☐	Lots of moles
☐	☐	History of tanning beds
☐	☐	Do you use sunscreen regularly?
☐	☐	Do you wear hats in the sun?
☐	☐	History of cold sores
☐	☐	History of skin infection
☐	☐	Radiation exposure

SOCIAL HISTORY

Smoking: ☐ cigarettes ☐ pipe ☐ cigar ☐ none

Number of years_____ Daily amount_____

Alcohol: ☐ beer ☐ wine ☐ other liquors ☐ none

Amount per week:_____

Do you use marijuana? ☐ Yes ☐ No

Other recreational drugs ☐ Yes ☐ No

If female, are you or could you be pregnant:

☐ Yes ☐ No

I certify that this history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

_____

Patient Signature Date

_____

Physician Signature Date

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COSMETIC QUESTIONAIRE

Your Name: _____ Date: _____

How did you hear about us? ❑ Friend ❑ Relative ❑ Doctor Referral (name)_____

❑ Internet: (❑Website ❑Google ❑Yahoo ❑Yelp ❑ CitySearch ❑ RealSelf ❑ Liposuction.com ❑ Bing)

❑ Magazine (❑ Seattle Metropolitan) ❑ Other _____

If you have any specific cosmetic interests, please check all that apply:

❑ Body Liposuction
❑ Neck Liposuction
❑ Eyelid Lift (Blepharoplasty)
❑ Fat Injection
❑ Laser Resurfacing / CO2
❑ Fraxel Dual
❑ Thermage
❑ IPL – Photo Rejuvenation
❑ VBeam Perfecta
❑ KTP
❑ Ear Surgery

❑ Leg Vein Treatment
❑ Spider Vein Treatments
❑ Leg Vein Treatment
❑ LightSheer Duet Laser Hair Removal
❑ Botox Cosmetic
❑ Xeomin
❑ Dysport
❑ Restylane
❑ Perlane
❑ Radiesse

❑ Juvederm
❑ Hand Aging
❑ Lip Augmentation
❑ Latisse
❑ Chemical Peels
❑ Skin Care Products: Obagi, Skin Ceuticals, Skin Medica
❑ Botox for Excessive Sweating
❑ Facial / Body Aging

Have you had any previous cosmetic surgery? ❑ yes ❑ no
If yes, please list: _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

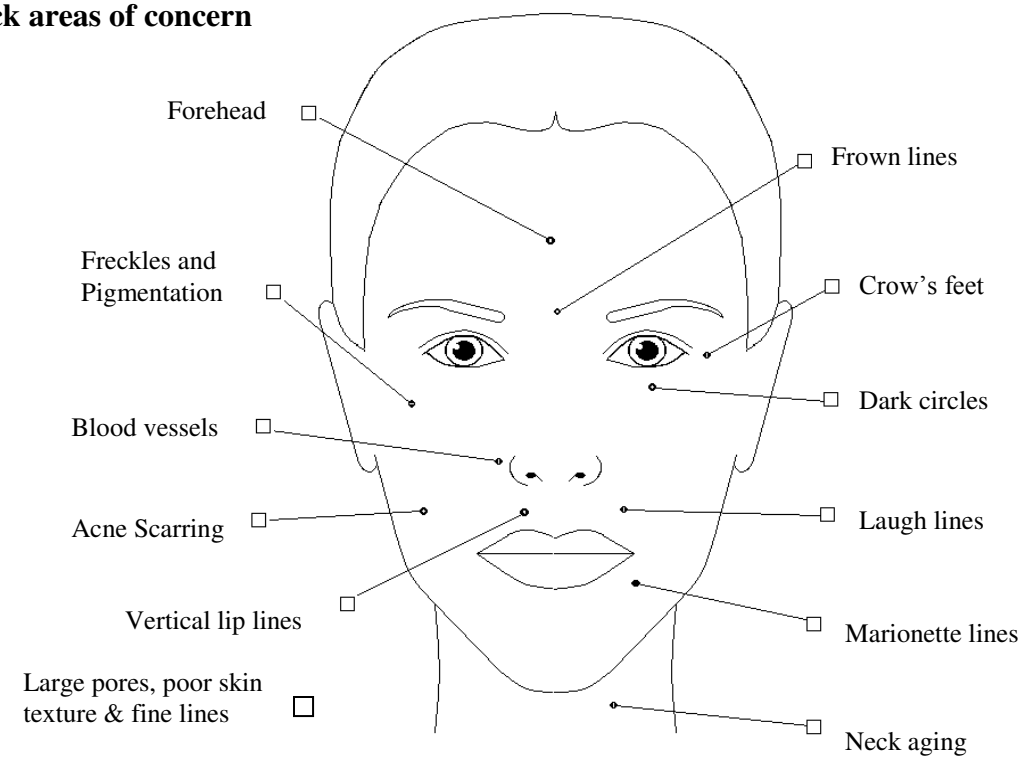
When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

Each day, I look at myself in the mirror

Once or Twice per day		*Every now and then to freshen up*		*More than 10 times per day*
1	2	3	4	5

Check areas of concern



Pacific Dermatology & Cosmetic Center

Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____	_____
Patient or legally authorized individual	Date
_____	_____
Printed Name if signed on behalf of Patient	Relationship (parent, legal guardian, Personal representative)

Notations:

This form will be retained in your medical records.

PACIFIC DERMATOLOGY & COSMETIC CENTER

Acknowledgement of Financial Responsibility

Pacific Dermatology provides both medical services covered by insurance and non-covered services that insurance will not pay for. Even if you have insurance, you may still have to pay some or all of the cost of your treatment. This is because of the copay, coinsurance and deductible of your individual policy. We urge you to call your insurer at the number on your insurance card if you do not know what your benefits and responsibilities are. If you are concerned about your ability to pay your bill, we are happy to discuss this with you before treatment.

If you do not have your insurance card with you, we require your social security number for identification. Our insurance company contracts require us to collect copays when you are seen. If you have a copay, it is due before you see the provider. If for some reason you cannot pay and we have to bill you, we charge an additional $5 administrative fee.

We will bill your insurance company for any covered services. If you receive non-covered services, you are responsible for paying that bill before you leave the office. You may receive both types of services during one visit. For example, you may be seen for a skin check and have skin tags removed. The skin check is a medical procedure and will be billed to your insurance but removing skin tags is a non-covered service you would pay for at that visit.

After we receive any insurance payments, we will bill you for the balance, if any, of the amount allowed by your insurance company.

If you are a surgical patient, you may be charged a facility fee. All Mohs patients whose wound is repaired (stitched up) here and most excision patients will be charged a facility fee. This covers our expenses for maintaining and operating our accredited ambulatory surgical center. (The doctor's payment is reduced for procedures performed in an ambulatory surgery center.)

Insurers consider procedures in an ambulatory surgical center out-patient surgery. Some insurance plans require an increased coinsurance payment for these procedures – **Medicare does not.**

* * *

Cosmetic consults are meetings with a provider to discuss possible cosmetic treatments. If your questions result in discussion or treatment of a medical nature, for example about acne, melasma, rosacea or a mole or your provider writes you a prescription, the visit is not a cosmetic consult and your insurer or you will be charged for an office visit.

We charge $50 for a missed appointment or a cancellation with less than 24 hours notice.

Payment for all non-covered services is required at the time of service. We do not bill for these.

By signing this acknowledgement you agree you are financially responsible for the services you receive and that you will pay your bill promptly. Bills unpaid after 90 days will be sent to our collection agency.

_____

Signature of Patient or Responsible Party Date

No treatment will be performed until this document has been signed. It will be filed permanently in your medical record. We will be happy to provide you a copy if you want one.

Pacific Dermatology Surgery Center / Pacific Dermatology & Cosmetic Center

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