Main Clinic
1618 S Millennium Way Ste 100
Meridian ID 83642
(208) 884-3376

Ada West DERMATOLOGY

Ten Mile Clinic
4574 N Ten Mile Rd Ste 120
Meridian ID 83646
(208) 884-3376

ADULT PATIENT INFORMATION

Name:_____
(**Last**) (**First**) (**MI**)

Date of Birth: _____ Gender: ☐ Male ☐ Female

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

Driver's License #: _____ Social Security #: _____

DEMOGRAPHIC INFORMATION

√	**Preferred Language**
	English
	Spanish
	Other:

√	**Ethnicity**
	Decline to Specify
	Hispanic or Latino
	Not Hispanic or Latino
	Unknown

√	**Race**
	Decline to Specify or Other Race
	White
	American Indian or Alaska Native
	Asian
	Black or African American

CONTACT INFORMATION

How do you prefer to receive appointment reminders? ☐ Home phone (land line) ☐ Cell phone (text only) ☐ Email

Emergency Contact: _____ Relationship: _____ Phone: _____

Patient Home Phone: _____**Patient** Work Phone: _____**Patient** Cell Phone: _____

Please indicate preferred phone: ☐ **Home** ☐ **Work** ☐ **Mobile**

Is it okay to leave a detailed message on your answering machine/voicemail if you are unavailable? ☐ **Yes** ☐ **No**

Email Address (**please PRINT clearly**): _____

Mailing Address: _____
(**Street or PO Box**) (**City**) (**State**) (**Zip**)

Preferred Pharmacy: Name: _____ Street: _____ City: _____

Primary Care Physician: Last Name: _____ First Name: _____

ASSIGNMENT OF BENEFITS: I hereby assign all applicable benefits and direct that payment be made directly to Ada West Dermatology for all services provided to/for me during my visits.

RELEASE OF INFORMATION: I authorize Ada West Dermatology to furnish medical and other information necessary to process claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care. This release of information will remain in effect until revoked by me in writing.

MEDICATION HISTORY CONSENT: By signing below, I authorize Ada West Dermatology to access my relevant pharmacy prescription data (including medication history from other medical providers) electronically through Sure-Scripts or similar programs.

TREATMENT AUTHORIZATION: The patient willfully requests treatment and consents to services provided by, or at the direction of the physicians, their physician assistants, or their nurse practitioner. I authorize a copy of this document to be used in place of the original.

NOTICE OF PRIVATE PRACTICES: As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by Ada West Dermatology.

Signature of Patient *or* **Representative** (Please Circle *One*): _____ **Date:** _____

Patient's Representative Name: _____ **Authority:** _____
(if signed by the patient's Legal Representative, please **PRINT** name and describe authority to act for the individual)

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Patient Name:	DOB:

Past Medical History: (please check all that apply) ☐ **NONE**

	Anxiety		Elevated Blood Pressure		Leukemia
	Appendectomy		Diabetes		Lymphoma
	Arthritis		End Stage Renal Disease		Lung Cancer
	Asthma		GERD (Gastroesophageal Reflux Disease)		Breast Cancer
	Atrial Fibrillation		Hearing Loss		Colon Cancer
	Cholecystectomy (Gall Bladder)		Heart Valve Replacement		Prostate Cancer
	Hepatitis (A, B, or C)		Hernia		Radiation Therapy
	COPD (Chronic Obstructive Lung Disease)		HIV/AIDS		Seizure
	Stroke		Hypercholesterolemia (High Cholesterol)		Bone Marrow Transplantation
	CAD (Coronary Artery Disease)		Hyperthyroidism (Overactive Thyroid)		
	Depression		Hypothyroidism (Underactive Thyroid)		

Other: _____

Past Surgical History: (please check and circle all that apply) ☐ **NONE**

	Biopsy of Breast		Hysterectomy (Uterus Removal)		Orchidectomy (Testicle Removal) (Left, Right, Both)
	Biopsy of Prostate		Kidney Biopsy		Replacement of Hip Joint (Left, Right, Both)
	Coronary Artery Bypass		Kidney Stone		Replacement of Knee Joint (Left, Right, Both)
	Kidney Transplant		Lumpectomy of Breast (Left, Right, Both)		Kidney Transplant
	Excision of Melanoma		Mastectomy (Left, Right, Both)		Heart Transplant
	Tubal Ligation		Oophorectomy (Ovary Removal) (Left, Right, Both)		Liver Transplant
	Heart Valve Replacement		Prostatectomy (Prostate Removal)		Tympanostomy (Ear Tubes)
	Hernia		Tonsillectomy and/or Adenoidectomy		
	Colectomy (Colon Removal)		Nephrectomy (Kidney Removal) (Left, Right)		

Other: _____

Skin Disease History: (please check and circle all that apply) ☐ **NONE**

	Acne		Eczema		Flaking or Itchy Scalp
	Actinic Keratosis		Malignant Melanoma		Psoriasis
	Biopsy of Skin		Hay Fever		Blistering Sunburn
	Dry Skin		Basal Cell Carcinoma		
	Dysplastic Nevus (Precancerous Mole)		Squamous Cell Carcinoma		

Other: _____

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Patient Name:	**DOB:**

Do you wear Sunscreen? ☐ YES ☐ NO If yes, what SPF? _____

Do you *currently* tan in a tanning bed? ☐ YES ☐ NO

Do you have a family history of Melanoma skin cancer? (**Melanoma only**, not Basal Cell or Squamous Cell Carcinoma)

☐YES ☐NO If yes, which relative(s)? _____

Medications: (Please list all current medication information, or attach a current medication list)

☐ **NONE**

Name	Strength	How Many?	How Often?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

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Patient Name:	**DOB:**

Allergies: (please list all allergies) ☐ **NONE**

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Occupation: _____

Immunizations:

*Patients **18** years or older:*

Date of most recent influenza immunization: **_____**

*Patients **65** years or older:*

Have you received your pneumonia vaccination? ☐ YES ☐ NO

Alerts: Do you have any of the following? (please mark **yes** or **no**)

Alert	Yes	No
Allergy to latex		
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within past two years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to procedures		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		

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Patient Name:	**DOB:**

☐ **Check here if you are "SELF PAY" (skip insurance section, read financial policy, sign and date form)**

INSURANCE INFORMATION (Please Fill Out Completely)

Primary Insurance		Secondary Insurance	
Policy or ID Number		Policy or ID Number	
Policy Holder's Name	Relationship to Patient	Policy Holder's Name	Relationship to Patient
Policy Holder's Social Security #	Policy Holder's Date of Birth	Policy Holder's Social Security #	Policy Holder's Date of Birth
Policy Holder's Employer		Policy Holder's Employer	

I have read and understand the financial policy written below and my questions have been answered to my satisfaction

Signature of Patient/Guardian: _____Date: _____

FINANCIAL POLICY (Please Read Carefully)

Ada West Dermatology is committed to providing quality medical services at reasonable cost. In order to ensure effective communication between you and our practice, we have adopted the following financial policy. If you have any questions concerning this policy, please discuss them with our billing department.

Patients ***with insurance coverage*** are ultimately responsible to understand the specifics of their individual insurance policies. The patient retains ultimate responsibility for financial charges. Please contact your insurance company at the phone number provided on the back of your insurance card for your policy details.

Patients ***without insurance coverage*** are ultimately responsible for financial charges. We require payment of services prior to the visit and/or procedure.

We may provide services in our facility, such as blood work or pathology, that are sent to outside sources. If your insurance requires specific providers of service to be used, or if you have any questions regarding the cost of service, please notify a staff member before services are rendered.

We require payment of co-payment, deductibles and co-insurances at time of visit and/or procedure upon check-out. If this is not possible, please discuss this with our billing department before services are rendered. If you are unable to make your payment at check-in, you may be asked to reschedule your appointment.

I understand and agree that I am responsible for payment of all charges, including those not paid by my insurance, in a reasonable time. Small balance credits of less than $1.00 will be written off of my account. Unpaid balances over 30 days will accrue 1.5% interest monthly.

Please provide a current copy of your insurance card. If proof of insurance is not provided, you will be required to make payment in full.

If there are any questions or concerns about cost of services, please ask to speak with a member of our billing department. We are very sensitive to your individual financial constraints. If necessary, we encourage patients to contact our billing department to arrange an acceptable payment schedule.

PLEASE NOTE: An outstanding balance greater than 90 days will be sent to an outside agency for collections.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (Optional)

Patient Name: _____ Date of Birth: _____

I hereby authorize Ada West Dermatology to disclose the specific information described below only for the purpose(s) and to the individual(s) also described below.

Description of the specific information to be disclosed:

□ Appointment Information
□ Visit or Progress Notes
□ Lab Tests/Results
□ Imaging Results
□ Diagnosis/Care Plan
□ Medications
□ Billing
□ Other: _____
□ Any and All Information

Confidential Information to be disclosed: *(please note this information will not be released if not checked)*

□ Mental Health Information
□ HIV Information
□ Alcohol/Drug Information
□ Genetic Testing Information

Purpose(s) for this authorization is (check all that apply):

□ Individual's Request
□ Medical Care
□ Other: _____

Recipient(s) of information:

Name	Date of Birth	Relationship	Phone Number

This authorization shall remain in effect one year from the date signed or:

□ Five (5) years from date signed

I acknowledge and understand that:

- This authorization is giving Ada West Dermatology the right to disclose my medical information to the individual(s) listed above.
- I may inspect and/or receive a copy of the information described on this authorization by completing this form and signing below.
- I have the right to revoke this authorization at any time by providing written notice to Ada West Dermatology, except to the extent that action has already been taken based on this authorization.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA Privacy Regulations.
- This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Signature of Patient **or** Representative: _____ Date: _____

Representative Name (printed): _____ Authority: _____
(If signed by the patient's Personal Representative, please print name and describe authority to act for the individual.)