

**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

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## ADULT PATIENT INFORMATION

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**Name:** \_\_\_\_\_  
(Last) (First) (MI)  
Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
Marital Status:  Single  Married  Separated  Divorced  Widow  Other  
Driver's License #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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## DEMOGRAPHIC INFORMATION

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<input checked="" type="checkbox"/>	<b>Preferred Language</b>	<input checked="" type="checkbox"/>	<b>Ethnicity</b>	<input checked="" type="checkbox"/>	<b>Race</b>
	English		Decline to Specify		Decline to Specify or Other Race
	Spanish		Hispanic or Latino		White
	Other:		Not Hispanic or Latino		American Indian or Alaska Native
			Unknown		Asian
					Black or African American

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## CONTACT INFORMATION

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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.)

# Ada West DERMATOLOGY

<b>Patient Name:</b>	<b>DOB:</b>
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**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: \_\_\_\_\_

<b>Patient Name:</b>	<b>DOB:</b>
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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.			

<b>Patient Name:</b>	<b>DOB:</b>
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**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		

<b>Patient Name:</b>	<b>DOB:</b>
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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.

**FINANCIAL ACKNOWLEDGMENT**

1. Co-pay, co-insurance and deductibles will be collected at check out.
2. Ada West Dermatology will submit your claim to your insurance company for all charges incurred at the time of service.
3. Uninsured patients are required to make payment at check-in. At check-out, the full balance is due for additional charges.
4. After your insurance company processes the claim, you may receive the following additional charges:
  - a. Office visit co-pay
  - b. Charges for procedures performed by the provider
  - c. Pathology costs
  - d. Additional pathology tests
5. I understand and agree that I am responsible for payment of all charges, including those not paid by my insurance.

**Patient Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Imaging Results     | <input type="checkbox"/> Billing                 |
| <input type="checkbox"/> Visit or Progress Notes | <input type="checkbox"/> Diagnosis/Care Plan | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Lab Tests/Results       | <input type="checkbox"/> Medications         | <input type="checkbox"/> Any and All Information |

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

- |  |  |
|--|--|
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> Alcohol/Drug Information    |
| <input type="checkbox"/> HIV Information           | <input type="checkbox"/> 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 a Personal Representative, please print name and describe authority to act for the individual.)