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**) (**Middle**)

Date of Birth:_____ Social Security #:_____ Driver's License #:_____

Birth Gender: ☐ Male ☐ Female Gender Identity:_____

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

DEMOGRAPHIC & CONTACT INFORMATION

Preferred Language:	**Race:**
English	Decline to Specify
Spanish	White
Other:	American Indian or Alaska Native
	Asian
	Black or African American
	Other:

Preferred Appointment Reminder: ☐ Phone ☐ Email ☐ Text ☐ Decline Reminders

Emergency Contact: _____ **Relationship:**_____ **Phone:** _____

Patient Home Phone:_____ **Patient Work Phone:**_____ **Patient Mobile Phone:**_____

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.

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: _____ **Date:** _____

Representative Name (printed): _____ **Authority:** _____

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

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☐ Check here if you are uninsured (skip insurance information, read financial policy, sign & date form below)

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	

FINANCIAL POLICY: (Please read carefully and sign below)

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.

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. Co-pay, co-insurance and deductibles will be collected at check out.

Ada West Dermatology will submit your claim to your insurance company for all charges incurred at the time of service.

Patients ***with insurance coverage*** are 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 responsible for financial charges. We require payment of services prior to the visit and/or procedure. Uninsured patients are required to make payment at check-in. At check-out, the full balance is due for additional charges.

We may provide services in our facility, such as blood work or pathology, which is 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. After your insurance company processes the claim, you may receive the following additional charges: Office visit co-pay, Charges for procedures performed by the provider, Pathology costs, and Additional pathology tests.

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.

No Show fees: Appointment no-shows or cancellations less than 24 hours in advance will be charged $35.

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 collection.

I have read and understand the treatment & financial policy. I certify that all my questions have been answered to my satisfaction.

Signature of Patient:_____ **Date:** _____

Representative Name (printed): _____ **Authority:** _____

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

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Patient Name: **DOB:**

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

	Anxiety		Diabetes		Hypothyroidism (Underactive Thyroid)
	Arthritis		Elevated Blood Pressure		Leukemia
	Asthma		End Stage Renal Disease		Lymphoma
	Atrial Fibrillation		GERD (Gastroesophageal Reflux Disease)		Radiation Therapy
	CAD (Coronary Artery Disease)		Hepatitis (A, B, or C)		Seizure
	Cancer, Type:		HIV/AIDS		Stroke
	COPD (Chronic Obstructive Pulmonary Disease)		Hypercholesterolemia (High Cholesterol)		
	Depression		Hyperthyroidism (Overactive Thyroid)		

Other: _____

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

	Coronary Artery Bypass		Hysterectomy (Uterus Removal)		Replacement of Knee Joint (Left, Right, Both) Year:
	Bone Marrow Transplant		Mastectomy (Breast Removal) (Left, Right, Both)		Transplant:_____
	Colectomy (Colon Removal)		Nephrectomy (Kidney Removal) (Left, Right)		Tubal Ligation
	Excision of Melanoma		Oophorectomy (Ovary Removal) (Left, Right, Both)		
	Heart Valve Replacement		Replacement of Hip Joint (Left, Right, Both) Year:		

Other: _____

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

	Acne		Blistering Sunburn		Malignant Melanoma
	Actinic Keratosis		Dry Skin		Precancerous Moles
	Basal Cell Carcinoma		Eczema		Psoriasis
	Biopsy of Skin		Flaking or Itchy Scalp		Squamous Cell Carcinoma

Other: _____

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? □ YES □ NO

If YES, which relative(s)? _____

(**Melanoma ONLY**, not Basal Cell Carcinoma or Squamous Cell Carcinoma)

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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.			

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

1
2
3
4
5

Occupation: _____

Immunizations:

Patients **18** years or older: Most recent influenza immunization? Date:_____	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	Alert:	Yes	No
Allergy to Latex			Blood Thinners		
Allergy to Adhesive			MRSA		
Allergy to Lidocaine			Pacemaker		
Allergy to Topical Antibiotic Ointments			Premedication Prior to Procedures		
Artificial Heart Valve			Rapid Heartbeat with Epinephrine		
Artificial Joints Within Past Two Years			Pregnancy or Planning a Pregnancy		

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Patient Name:	**DOB:**

Authorization to Disclose Protected Health Information

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

Confidential information to be disclosed: (Please note this information will only be released if checked):

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

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

☐ At the Request of the Individual ☐ Other: _____

Recipient(s) of information:

Name	Date of Birth	Relationship	Phone Number

This authorization will remain in effect one year from 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 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 re-disclosure 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.
- If PHI (Protected Health Information) is sold or used in marketing involving financial remuneration, the remuneration will be to the covered entity.

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.)