Ada West
DERMATOLOGY

ADULT PATIENT INFORMATION-Page 1

Name:_____
(Last Name) (First Name) (Middle Name)

Date of Birth:_____ **Birth Sex**: ☐ Male ☐ Female **Gender Identity**:_____
(Optional)

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

DEMOGRAPHIC & CONTACT INFORMATION

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

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

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

Patient Home Phone:_____**Patient Mobile Phone:**_____
Preferred Phone: ☐ Home ☐ Mobile

Is it ok 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 Code)

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

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

INSURANCE INFORMATION (Required)

☐ Check here if you are **NOT INSURED** (If not insured, please skip insurance information section)
Primary Insurance:_____**Policy or ID #**_____

Primary Policy Holder Name:_____**Date of Birth**:_____

Primary Policy Holder Relationship to Patient:_____

Primary Policy Holder's Employer:_____

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Secondary Insurance:_____**Policy or ID#**_____

Secondary Policy Holder Name:_____**Date of Birth**:_____

Secondary Policy Holder Relationship to Patient:_____

Secondary Policy Holder's Employer:_____

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ADULT PATIENT INFORMATION-Page 2

Patient Name: **DOB:**

Past Medical Conditions (Please check all that apply)

☐ None	☐ Coronary artery disease	☐ Human immunodeficiency virus infection (HIV)
☐ Anxiety disorder	☐ Depressive disorder	
☐ Arthritis	☐ Diabetes mellitus	☐ Hypercholesterolemia
☐ Asthma	☐ End-stage renal disease	☐ Hyperthyroidism (High)
☐ Atrial fibrillation	☐ Gastroesophageal reflux disease	☐ Hypothyroidism (Low)
☐ Cancer, Type:	☐ Hypertension (High Blood Pres)	☐ Leukemia
☐ Cerebrovascular accident (Stroke)	☐ Hearing loss	☐ Malignant lymphoma
☐ Chronic hepatitis (A or B or C?)	☐ History of radiation therapy	☐ Other

Past Surgeries (Please check all that apply)

☐ None	☐ History of colectomy	☐ Tonsillectomy and adenoidectomy
☐ Biopsy of skin	☐ Hysterectomy	
☐ Coronary artery bypass graft	☐ Mastectomy of left breast	☐ Total knee replacement
☐ Excision of melanoma	☐ Mastectomy of right breast	☐ Total nephrectomy-kidneys
☐ H/O: tubal ligation	☐ Oophorectomy-Ovaries removal	☐ Tympanostomy (Ear tubes)
☐ Heart valve replacement	☐ Prosthetic arthroplasty of the hip	☐ Other

Skin Conditions (Please check all that apply)

☐ None	☐ Dysplastic nevus	☐ History of squamous cell carcinoma
☐ Acne	☐ Eczema	
☐ Actinic keratosis	☐ H/O Malignant melanoma	☐ Pruritus of scalp
☐ Biopsy of skin	☐ History of malignant basal cell Neoplasm of skin	☐ Psoriasis
☐ Dry Skin		☐ Sunburn of second degree

☐ Other

Skin Protection

Do you wear sunscreen? ☐ Yes ☐ No If Yes, what SPF?_____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No (If yes please check all that apply)

☐ None	☐ Daughter	☐ Niece
☐ Mother	☐ Son	☐ Grandmother
☐ Father	☐ Uncle	☐ Grandfather
☐ Sister	☐ Aunt	☐ Grandson
☐ Brother	☐ Nephew	☐ Granddaughter

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Patient Name:	**DOB:**

Medications: ☐ **None** or please list all current medication information below or ☐ Current medication list is attached

Name of medication/supplement	Strength (i.e. 100)	Unit (i.e. mg)	Dosage (How Many)	Frequency (How Often)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Allergies: ☐ **None** or please list all allergies below.

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Occupation:_____

Alerts: Do you have any of the following? (Please check yes or no)

Condition/Alert	Yes	No	Condition/Alert	Yes	No
Allergy to Latex			Defibrillator		
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 the Past Two Years			Pregnancy or Planning a Pregnancy		
Blood Thinners					

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ADULT PATIENT INFORMATION-Page 4

Patient Name: **DOB:**

Authorization to Disclose Protected Health Information (PHI)

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 apply):

☐ At the Request of the Individual ☐ Other: _____

Recipient(s) of information: (NOT for healthcare providers)

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 gives 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 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.
- 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.)

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Patient Name: **DOB:**

☐ **Check here only if you are uninsured, meaning you do not carry or have insurance. Read the policies & sign below.**

POLICIES FOR TREATMENT

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 PRIVACY PRACTICES: As required by law, I have been given a copy of the Notice of Privacy Practices followed by Ada West Dermatology.

FINANCIAL POLICY

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

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.

Patients ***with insurance coverage*** are responsible for understanding 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, 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. 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 any Additional pathology tests.

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 my account.

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 and financial policy. I certify that all my questions have been answered to my satisfaction.

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

If Personal Representative, Name: _____ **Authority:** _____

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