Pacific Dermatology – Dr. Basheer Badiei

15613 SE Mill Plain Blvd. Vancouver, WA 98684

Today's Date: _____

Patient's Name: _____ **Date of Birth:** ____/____/_____ **Age:** _____

SSN: ____-____-_____ **Marital Status:** _____ **Spouse's Name:** _____

Parent/Guardian Name (if patient is under 18):_____Email _____

Address: _____

Phone #: (_____)_____-_____ **Alternate Phone #:** (_____)_____-_____

Is it OK to leave a phone message for lab and biopsy results? **If YES initial here: _____**

Emergency Contact (Name, Relationship, Phone #): _____

Occupation/Employer:_____ **Primary Physician:** _____

Preferred Pharmacy:_____ **How did you hear about us?**_____

Medication Allergies:_____

Current Medications: _____

_____

Are you currently experiencing any of the following? (check all that apply):

☐ Chills	☐ Fever	☐ Fatigue	☐ Weight change	☐ Joint pain
☐ Back pain	☐ Muscle pain	☐ Blurred vision	☐ Eye pain	☐ Sensitivity to light
☐ Dizziness	☐ Headaches	☐ Weakness	☐ Hearing problems	☐ Congestion
☐ Runny nose	☐ Sore throat	☐ Easy bruising	☐ Bleeding	☐ Hair loss
☐ Chest pain	☐ Palpitations	☐ Swelling	☐ Heat/cold intolerance	☐ Allergies
☐ Frequent illnesses	☐ Cough	☐ Trouble breathing	☐ Abdominal pain	☐ HIV exposure
☐ Hives	☐ Heartburn	☐ Constipation	☐ Diarrhea	☐ Stool changes
☐ Anxiety	☐ Depression	☐ Sleep disturbances	☐ Genital lesions	☐ Blood in urine
FEMALES:	☐ Pregnancy	☐ Menstrual problems	☐ Abnormal vaginal bleeding/discharge	

Patient's Medical History (if yes, please specify the condition):

Yes	No		Yes	No	
☐	☐	Heart/Circulation_____	☐	☐	Skin Problems_____
☐	☐	Lungs/Breathing_____	☐	☐	Skin Cancers_____
☐	☐	Stomach/Intestinal_____	☐	☐	Lupus/Auto-Immune_____
☐	☐	Genital Urinary_____	☐	☐	Internal Cancers_____
☐	☐	Muscle/Bone_____	☐	☐	Communicable Diseases_____
☐	☐	Diabetes/Thyroid_____	☐	☐	Ear/Nose/Throat_____
☐	☐	Nervous/Sensory_____	☐	☐	Psychiatric/Cognitive_____
☐	☐	Blood/Lymph_____	☐	☐	Surgery within the Last Year
☐	☐	Allergies/Hay Fever_____			_____

Do you smoke tobacco? ☐ Yes ☐ No If yes, how much per week? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week? _____

Continued on Back ➔

Pacific Dermatology – Dr. Basheer Badiei

15613 SE Mill Plain Blvd. Vancouver, WA 98684

Family Medical History (if yes, please specify the condition and relation to patient):

Yes	No		Yes	No	
☐	☐	Diabetes_____	☐	☐	Eczema_____
☐	☐	Thyroid_____	☐	☐	Psoriasis_____
☐	☐	Allergies/Hay Fever_____	☐	☐	Skin Cancers_____
☐	☐	Asthma_____	☐	☐	Other Skin Problems_____
			☐	☐	Lupus/Auto-Immune_____

Consent for Treatment and Acknowledgment of Receipt of Notice

Consent for Treatment: I authorize Pacific Dermatology, PC and its personnel to provide ongoing medical care, treatment and procedures as ordered by the physicians and/or other health care providers/ I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

Missed/No show Appointments: No show for regular office visit x 2 appointments will result in a $25.00 rescheduling fee. After 3rd no show, Dr. patient relationship may be terminated. No show for surgical and/or cosmetic treatment appointments (laser, Fillers, etc.) may result in a $50.00 rescheduling fee.

Financial Agreement: I understand and agree that I (or parent, if patient is a minor) am financially responsible for all services provided. I also understand that if the reason for my visit is deemed cosmetic, and therefore not covered by my insurance carrier, I am financially responsible for the cost of this visit an/or treatment. As a courtesy Pacific Dermatology, PC will bill my insurance carrier. Regardless of outstanding insurance claims, full payment of outstanding balances is due within 90 days of the date of service or a 10 percent finance charge will apply. If my account is referred to a collection agency, I understand that I am responsible for reasonable collection expenses, including attorney's fees.

Assignment of Benefits: I authorize my insurance benefits to be paid directly to Pacific Dermatology, PC. I certify that all information given in applying for payment under the Social Security Act or other health insurance plan is correct and authorize verification of coverage by Pacific Dermatology, PC. A photocopy of this authorization shall be considered as effective and valid as the original.

Insurance Coverage and benefit Verification: I understand that it is my responsibility to verify with my insurance company that I have active coverage and that Pacific Dermatology, PC is contracted with my insurance carrier. I also understand that it is my responsibility to make pacific Dermatology, PC aware of any required authorization by my plan for any office visits and/or procedures.

Medicaid Members Financial Agreement: It has been explained to me that Pacific Dermatology, PC is not a contracted provider with DSHS-Medicaid. I understand that Medicaid will not be billed and any remaining balance after my primary insurance has been billed is my financial responsibility.

Consent to Release of Information: I authorize Pacific Dermatology, PC to release to my insurance carrier(s), including Medicare, Medicaid and any other reimbursing agency, information about my identity, treatment, diagnosis, prognosis and/or services rendered (including drug and alcohol abuse treatment, mental health treatment, diagnosis and/or treatment of HIV/AIDS-related illness or sexually transmitted disease) as permitted by state and federal law which may be required or requested, thus releasing Pacific Dermatology from any liability for furnishing such information. I understand information may be released through electronic or paper media.

Notice if Health Information Practices: I acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

Name and Relationship:_____ _____

to patient, if not signed by patient **Date**