Pacific Dermatology – Dr. Basheer Badiei

15613 SE Mill Plain Blvd. Vancouver, WA 98684

Patient Name: _____ **Today's Date:** _____

Date of Birth: ____/____/_____ Age**:** _____ **SSN:** _____ **Marital Status:** _____

Address: _____

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

Spouse's Name: _____

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

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

I give permission to release personal health information to the following individual:

Name: _____ **Relationship:** _____

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

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

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

Medication Allergies: _____ **Latex Allergy? Yes No**

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	☐ Breast Feeding	☐ Menstrual Problems/Abnormal Bleeding	

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, If yes, how much per week? _____

☐ No

Do you drink alcohol?

☐ Yes, If yes, how much per week_____

☐ No

Continued-on back ⏩

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. **Initials_____**

Missed, Cancelled, & Rescheduled Appointments Pacific Dermatology, PC requires at least 24-hour notice for all appointment cancellations or changes. A $50 fee ($100 for surgical appointments) will be billed directly to the patient or financially responsible representative for missed appointments or failure to give at least 24 hours advance notice for appointment cancellations or changes. After three missed appointments, cancellations, or appointment changes without 24-hour advance notice, or any combination of the above, the doctor-patient relationship may be terminated. I understand and agree with this policy.
Initials_____

Financial Agreement: I understand and agree that I (or guardian, 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 and/or treatment. As a courtesy Pacific Dermatology, PC will bill my insurance carrier for non-cosmetic charges. 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. **Initials_____**

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. **Initials_____**

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. **Initials_____**

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. I will also be asked to pay a deposit at the time of service towards my deductible or any co-insurance remaining from my primary insurance. **Initials_____**

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, PC from any liability for furnishing such information. I understand information may be released through electronic or paper media. **Initials_____**

_____ _____

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

Name and Relationship: _____ _____

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