EAST VALLEY DERMATOLOGY CENTER

Adult and Pediatric Dermatology

VALLEY SKIN CANCER SURGERY

PATIENT INFORMATION RECORD

Please Use Black Ink Only

Patient Information

Patient's Name_____
Last First Middle Initial

Address_____ Apt# _____ City_____ State____ Zip_____

Date of Birth_____ Age_____ Social Security #_____

Primary Phone: (_____) _____

☐ O.K. to leave message with detailed information (Extended) ☐ Leave message with call-back number only (Brief)

Secondary Phone: (_____) _____

☐ O.K. to leave message with detailed information (Extended) ☐ Leave message with call-back number only (Brief)

Work Phone: (_____) _____

☐ O.K. to leave message with detailed information (Extended) ☐ Leave message with call-back number only (Brief)

Email Address_____ Sex: ☐ Female ☐ Male

(For access to our Patient Portal and to receive promotional information on products sold at EVDC)

Emergency Contact_____ Phone #_____

Relationship to Patient: _____

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

Employer_____ If Student: ☐ Full Time ☐ Part Time

Referring Doctor_____ Phone #_____

In order for our healthcare practice to meet the qualification requirements under the American Recovery and Reinvestment Act of 2009, we are required to obtain the following information:

1. Ethnicity: ☐ Hispanic or Latino/a ☐ Non-Hispanic ☐ Do not wish to respond

2. Race: ☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ White ☐ Other Race
☐ Native Hawaiian or Other Pacific Island ☐ Hispanic ☐ Do not wish to respond

3. Language: ☐ English ☐ Other _____

Insurance Information

Primary Insurance_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Name_____ ☐ Other _____

Date of Birth _____ Phone_____ Social Security#_____

If different from patient:
Address_____ Apt#_____City_____State_____ Zip_____

Employer _____ Phone # _____

Secondary Insurance_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Name_____ ☐ Other _____

Date of Birth _____ Phone_____ Social Security#_____

If different from patient:
Address_____ Apt#_____City_____State_____ Zip_____

Employer _____ Phone # _____

Responsible Party

Name_____
Last First Middle Initial

Address_____ Apt#_____City_____State_____ Zip_____

Primary Phone # _____ Secondary Phone # _____

Date of Birth _____ Email Address _____

Employer _____ Phone # _____

Understanding Health Insurance Benefits

Co-Pay: This is the amount that you will be expected to pay upon check-in for each appointment. Specialist Co-payments may be higher than what you would normally pay for your PCP visits. Please be prepared to pay by Visa, MasterCard, Discover, Cash or Check at the time of service.

Deductible: This is an amount designated by your plan that you will pay for covered services each calendar year before your insurance plan begins to pay benefits for certain covered services. If you have a surgical deductible, then procedures such as biopsies, freezings, wart treatments etc. may be applied towards your surgical deductible.

Co-Insurance: This is the percentage of the visit or procedure that you will be responsible for. If you have a deductible in addition to co-insurance, your deductible must first be met before your insurance will begin to pay.

Once your insurance carrier has processed your claim, you will receive an invoice for any remaining patient responsibility. If you have any questions regarding your benefits, we recommend that you contact your insurance carrier directly to receive your specific coverage details.

Power of Attorney

If, during my status as a patient at East Valley Dermatology & Valley Skin Cancer Surgery, I become incapacitated, I have a Medical Power of Attorney to provide for my records: ☐ Yes ☐ No

Power of Attorney Name: _____ Phone #: _____

Pharmacy Information

Local Pharmacy Name: _____ Cross Streets: _____ City: _____

Mail Order Pharmacy Name: _____

AUTHORIZATION TO VIEW PRESCRIPTION HISTORY FROM EXTERNAL SOURCE

I authorize East Valley Dermatology Center & Valley Skin Cancer Surgery to view any and all available Prescription History from an External Source. I am aware that East Valley Dermatology Center & Valley Skin Cancer Surgery uses a secure connection to SureScripts to send and receive most prescriptions in the office.

_____ _____

(Signature of Patient or Responsible Party) (Date)

_____

(Relationship to Patient)

Authorization to Release Information, Assignment of Benefits and Notice of Privacy Practices:

I authorize the release of any/all information regarding my diagnosis and treatment to the following person(s) below, until I notify you otherwise:

Name(s): 1. _____ 2. _____ 3. _____

By signing below, I authorize payments of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted. My signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I also understand that if my account becomes delinquent and is referred to an outside collection agency, I may be contacted by the following methods including but not limited to pre-recorded/artificial voice messages and/or use of an automatic dialing device to the telephone numbers associated with my account.

I acknowledge that I have received The Notice of Privacy Practices.

Dermatology does NOT fall under Preventive/Well Visit coverage.
Patients will be responsible for Co-Pay/Deductible/Co-Insurance.

Must be 18 years or older to sign this authorization:

Patient's Name (*print*) _____

Responsible Party Signature _____ Date _____

*****No changes to this policy by the patient / responsible party will be acknowledged. Questions may be directed to office personnel.*****

1100 S. Dobson Rd., Suite 223 Chandler, AZ 85286 website: www.evderm.com
East Valley Dermatology ~ 480-821-8888 Valley Skin Cancer Surgery ~ 480-214-0388

East Valley Dermatology/Valley Skin Cancer Surgery

Patient Name: _____ Date of Birth: _____ Date: _____

Social History

Smoking Status? 0 Current Smoker 0 Former Smoker 0 Non Smoker

Have you had a drink containing alcohol in the past 12 weeks? 0 yes 0 no
If yes select frequency below:

0 0-6 drinks or 0 7 or more

Have you used recreational drugs in the past 12 months? 0 yes 0 no

Do you use sun protection? 0 always 0 almost always 0 sometimes 0 hardly never 0 never

Women only: Are you pregnant? 0 yes 0 no

Women only: If not, are you planning a pregnancy? 0 yes 0 no

Women only: Are you currently breastfeeding? 0 yes 0 no

SKIN TYPE

0 Always burns, never tans, extremely sun sensitive

0 Burns easily, then tans a little, very sun sensitive

0 Sometimes burns, then tans slowly, sun sensitive

0 Burns a little, always tans

0 Rarely burns, tans easily

0 Never burns, deeply colored

Family History 0 Unknown, Adopted

Mother 0 None 0 Heart Problems 0 Cancer 0 Eczema 0 Skin Cancer, Basal Cell
0 Skin Cancer, Squamous Cell 0 Skin Cancer, Type Unknown 0 Melanoma 0 Psoriasis

Father 0 None 0 Heart Problems 0 Cancer 0 Eczema 0 Skin Cancer, Basal Cell
0 Skin Cancer, Squamous Cell 0 Skin Cancer, Type Unknown 0 Melanoma 0 Psoriasis

Siblings 0 None 0 Heart Problems 0 Cancer 0 Eczema 0 Skin Cancer, Basal Cell
0 Skin Cancer, Squamous Cell 0 Skin Cancer, Type Unknown 0 Melanoma 0 Psoriasis

Children 0 None 0 Heart Problems 0 Cancer 0 Eczema 0 Skin Cancer, Basal Cell
0 Skin Cancer, Squamous Cell 0 Skin Cancer, Type Unknown 0 Melanoma 0 Psoriasis

Patient Name: _____ Date of Birth: _____ Date: _____

Past Medical History

- ○ No History of Skin Cancer
- ○ History of Skin Cancer, Basal Cell
- ○ History of Skin Cancer, Squamous Cell
- ○ History of Skin Cancer, Unknown Type
- ○ Melanoma
- ○ Chronic Acne
- ○ Eczema / Dermatitis
- ○ Psoriasis
- ○ History of specific skin disease
- ○ Problems with healing
- ○ Develop keloids (scars) after surgery
- ○ Latex – Skin allergies
- ○ Tape – Skin allergies
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Hepatitis C
- ○ Breast Cancer
- ○ Cervical Cancer
- ○ Prostate Cancer
- ○ Colon Cancer
- ○ Lung Cancer
- ○ Thyroid Cancer
- ○ Leukemia / Lymphoma
- ○ Cold sores / Herpes
- ○ Shingles
- ○ Hay Fever
- ○ Hives
- ○ Food Allergies
- ○ HIV / AIDS
- ○ TB (Tuberculosis)
- ○ MRSA (Staph)
- ○ Pacemaker
- ○ Implantable Defibrillator
- ○ High Blood Pressure
- ○ Stroke
- ○ Heart Attack
- ○ Phlebitis or Blood Clot
- ○ Diabetes
- ○ Lung Disease
- ○ Thyroid Disease
- ○ Kidney or Bladder Disease
- ○ Gastrointestinal Disease
- ○ Liver Disease
- ○ Colitis
- ○ Gluten Sensitivity
- ○ Yeast Infection (antibiotics)
- ○ Arthritis
- ○ Artificial Joints
- ○ Seizures
- ○ Lupus or connective tissue disease
- ○ Anemia
- ○ Blood transfusion
- ○ Immune suppression
- ○ Organ transplant
- ○ Anxiety
- ○ Depression

EAST VALLEY
DERMATOLOGY CENTER
Adult and Pediatric Dermatology

VALLEY SKIN
CANCER SURGERY
Dermatologic and Mohs Micrographic Surgery

Medication List and Medication Allergies

Date: _____

Patient Name: _____ Date of Birth: _____

Medications: Please list any current medications that you are taking, including over the counter.

Name of Medication	Strength	Dose

Allergies to Medications: Please list any medication allergies that you are aware of.

Name of Medication	Reaction

Provider Reviewed: _____ **MA Entered: _____**

EAST VALLEY DERMATOLOGY CENTER &
VALLEY SKIN CANCER SURGERY

Notice of Privacy Practices (Summarized)

Our practice is required by law to follow the procedures described in this summary. This is a summary of our Privacy Practices. You may see the full version, which is available upon request. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice applies to personal health information that we have about you, and which are kept in or by our medical practice. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Officer for this medical practice.

Who has access to your personal information?

We may use your personal health information to:

- Plan your treatment and services.
- Submit bills to your insurance, Medicaid, Medicare, or third party payer.
- Obtain approval in advance from your insurance company to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.
- Perform healthcare operations such as sharing your information with business associates who need to use or disclose your information to provide a service for our medical practice (such as our billing company).
- Exchange information with other State agencies as required by law.
- Treat you in an emergency.
- Treat you when there is something that prevents us from communicating with you.
- Send you appointment reminders.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- To agencies involved in a disaster situation.
- As required by State, Federal, or local law. This includes investigations, audits, inspections, and licensure.
- To law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To coroners, medical examiners, and funeral homes when necessary for them to do their jobs.
- When ordered to do so by the court.
- To Federal officials involved in security activities authorized by law.
- To the correctional facility if you are an inmate.

Patient Rights:

As a patient in our practice, you have the right:

- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To inspect and get a copy of your record (With some exceptions).
- To have access to your record by electronic format or through the patient portal.
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete. You must make this request in writing. We may deny your request if:
    - We did not create the entry that is wrong; or
        - The information is not part of the file we keep; or
        - The information is not part of the file that we would let you see; or we believe the record is accurate and complete
- To limit how we use or disclose information about you. For example – not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request.
- To know to whom we have sent information about you for up to the last six years. The first request in a 12 month period is free. We may charge you for additional requests.
- To have a paper copy of the Notice of Privacy Practices.
- To file a complaint if you believe any of your rights have been violated. All complaints must be in writing. You will not be penalized if you file a complaint. Send to:
  EVDC, Attn: Privacy Officer 1100 S. Dobson Rd. STE 223, Chandler, AZ 85286
- To tell us (authorize) other releases of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).
- To waive your right to use your insurance coverage and pay in full for your visit with an accepted method of payment at the time of service. Upon request to be self-pay, EVDC/VSCS will not disclose information to your insurance carrier. Request must be made in writing.
- Your information will not be sold for marketing or fundraising purposes without your written permission. 09/2013