**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

Primary Care Physician / 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*** **– Person responsible for receiving the financial statements.**

❑ **SELF**

❑ **Other – Please complete information below**

Name_____
Last First Middle Initial

Address_____ Apt#_____City_____State_____ Zip_____

Primary Phone # _____ Secondary Phone # _____

Date of Birth _____ Email Address _____

***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. _____

***Acknowledgment:***

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. *We prohibit audio or video recording if the intent is to share it on a public website. Also, if you are recording for your own personal use, we prefer you ask our consent.*

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? ○ Current Smoker ○ Former Smoker ○ Non Smoker

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

○ 0-6 drinks or ○ 7 or more

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

Do you use sun protection? ○ always ○ almost always ○ sometimes ○ hardly ever ○ never

**Women only**: Are you pregnant? ○ yes ○ no

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

**Women only**: Are you currently breastfeeding? ○ yes ○ no

**SKIN TYPE**

○ Always burns, never tans, extremely sun sensitive

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

○ Sometimes burns, then tans slowly, sun sensitive

○ Burns a little, always tans

○ Rarely burns, tans easily

○ Never burns, deeply colored

**Family History** ○ Unknown, Adopted

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

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

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

**Children** ○ None ○ Heart Problems ○ Cancer ○ Eczema ○ Skin Cancer, Basal Cell
○ Skin Cancer, Squamous Cell ○ Skin Cancer, Type Unknown ○ Melanoma ○ 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:** _____ **Gender at Birth:** ❑ **Male** ❑ **Female**

**Current gender you identify as:** ❑ **Male** ❑ **Female** ❑ **Other**

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

| Name of Medication | Strength | Dose |
|---|---|---|
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**Allergies to Medications:** Please list any medication allergies that you are aware of.

| Name of Medication | Reaction |
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**Provider Reviewed:** _____ **MA Entered:** _____