PATIENT MEDICAL HISTORY

Northwest Skin Specialists

Patient Name _____ Date of Birth ____/____/_____

Reason for today's visit _____ Primary Care Physician _____

Did a physician refer you to NWSS? ☐ Yes ☐ No If yes, who? _____

List ALL MEDICATIONS you are currently taking (prescriptions, over the counter, vitamins and herbals)

_____ _____ _____ _____ _____ _____

MEDICAL HISTORY

Please indicate if you have a history of any of the following. Mark all that apply

☐ High Blood Pressure	☐ Anemia	☐ Gluten Intolerance	☐ Asthma	☐ Tuberculosis
☐ Heart Condition	☐ Hair Loss	☐ Liver/Hepatitis	☐ Arthritis	☐ Mood Disorder (specify)
☐ Pace Maker/Defibrillator	☐ Diabetes	☐ Kidney Disease	☐ Artificial Joint	☐ Anxiety
☐ Artificial Heart Valve	☐ Thyroid	☐ Seizures Disorder	☐ Plastic Surgery	☐ Fainting during procedures
☐ Blood Clots	☐ Colitis	☐ Cancer (specify below)	☐ HIV	☐ Excessive Sweating
				☐ ADHD

List any other diseases, conditions (specify) _____

Have you ever had Skin Cancer? ☐ **No** ☐ **Basal** ☐ **Squamous** ☐ **Melanoma** ☐ **Other** _____

Family History of Skin Cancer? ☐ **No** ☐ **Basal** ☐ **Squamous** ☐ **Melanoma** ☐ **Other** _____

List any surgical procedures in the last six months_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, what medication and type of reaction _____

Have you ever had a bad reaction to dental anesthesia? ☐ Yes ☐ No If yes, type of reaction _____

Women: Are you pregnant? ☐ Yes ☐ No If Yes, Due Date ____/____/_____

Do you develop skin rashes in reaction to any of the following?

☐ Bandages ☐ Environment ☐ Food ☐ Medications ☐ Topical Neosporin ☐ Other _____

Do you have issues with any of the following?

☐ Problems with healing ☐ Develop abnormal (keloid) scars after healing ☐ Bleed easily ☐ Other_____

Are you interested in cosmetic treatment of the following?

☐ Blood Vessels ☐ Excessive sweating ☐ Skin regimen ☐ Unwanted hair ☐ Wrinkles ☐ None

SOCIAL HISTORY

☐ African American ☐ Asian ☐ American Indian ☐ Caucasian ☐ Hispanic ☐ Other ☐ Prefer not to disclose

Do you drink alcohol? ☐ Yes ☐ No If Yes, how often? _____

Do you smoke? ☐ Yes, currently ☐ Former ☐ Never

What is your occupation? _____ What are your hobbies? _____

_____ _____ _____ _____

Signature of patient (or guardian if a minor) Date Provider Signature Date

Northwest Skin Specialists, PCC

PATIENT REGISTRATION

Legal Name: _____
Last First Middle Initial Birthdate

Billing Address: _____
Street City/State Zip

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

How would you like to receive appointment reminders? □ Voice □ Text □ No Reminders

Which phone number would you like your appointment reminders to go to? □ Home □ Cell □ Work

Email Address: _____

Do we have permission to leave a detailed message regarding your health information at your phone numbers listed above?

Yes to: □ Home Phone □ Cell Phone □ Work Phone □ No detailed message

Social Security Number: _____ Employer: _____ Sex: □ M □ F □TG

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Widowed

Primary Care Physician: _____
Last First Phone

Referring Physician: _____
Last First Phone

Emergency Contact: _____
Name Relation Phone

Pharmacy Name & Location: _____ Phone #: _____

INSURANCE INFORMATION

Primary Subscriber Legal Name: _____
Last First Birthdate

Primary Subscriber Billing Address: _____
Street City/State Zip

Secondary Ins Subscriber Legal Name: _____
Last First Birthdate

Secondary Ins Subscriber Billing Address: _____
Street City/State Zip

PARENT OR GUARDIAN INFORMATION (if applicable)

Name: _____ Relationship to Patient: _____ Phone: _____

SSN:_____ Birthdate: _____ Is Parent/Guardian a patient at NWSS? □ Yes □ No

Address: _____
Street City/State Zip

PATIENT ACKNOWLEDGEMENT

The above information is true to the best of my knowledge.

_____ _____
Signature of Patient (or guardian if a minor) Date

Northwest Skin Specialists, PLLC

PATIENT AGREEMENT FINANCIAL POLICY

Patient Name: _____ **Birthdate:** _____

OFFICE POLICIES ALL APPOINTMENTS: We ask for 2 days notice for all reschedules and cancellations of appointments. This courtesy allows our office to schedule another patient in your place. If an emergency arises, please give as much notice as possible. Failure to show up to a scheduled appointment without a cancellation phone call will be subjected to a fee.

INSURANCE COVERAGE COMMERCIAL: I will be responsible for paying my copay at the time of my visit as required by my insurance. I will pay my annual deductible, co-insurance, and charges for any service/procedure deemed not medically necessary, pre-existing, or cosmetic by my insurance.

INSURANCE CARD: I will present my insurance card at the time of appointment as required by my insurance. Without the presence of my insurance card, I will need to pay in full at the time of service. I will be provided with a receipt which I may submit to my insurance company myself.

REFERRALS: If my insurance company requires a referral to see a specialist, I understand that I am responsible for obtaining this referral prior to my visit and renewing my referral when needed for subsequent visits. If I fail to do so, I agree to pay the entire unpaid balance remaining from insurance.

OTHER: I understand that my private insurance and/or commercial plan in which my physician is not a covered provider may be covered at a lower rate or not at all. I agree to take full financial responsibility for the entire unpaid balance left after payment from my insurance.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

NON-CONTRACTED INSURANCE: We do not accept the following insurance plans: DSHS, Medical coupons, Molina, Medicaid, Group Health Cooperative, Basic Health, Healthy Options and HMOs. This list is not all inclusive. It is my responsibility to check with my insurance carrier/policy regarding coverage.

UNINSURED: I understand that payment in full is due at the time of service and agree to pay my balance in full at that time.

MEDICARE PATIENTS Signature on file: I request payment of authorized Medicare benefits are made either to me or on my behalf to Northwest Skin Specialists, PLLC for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “Other health insurance” is indicated on the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of patient (or guardian if a minor) DATE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Northwest Skin Specialists~ Seattle, WA

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office a the address above to obtain a current copy of the *Notice of Privacy Practices.* The current copy is the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name:_____ Date of Birth:_____

Signature:_____

Date:_____

Relationship to
Patient:_____

Dependent family members also covered by this
acknowledgement:_____

I give authority for Northwest Skin to disclose my health info to the following people:

_____