Dermatology of Seattle

Patient Information: When registering, please present proof of insurance or Medicare. Payment is expected at the time of service unless special arrangements are made.

Name: _____ DOB: _____ Age: _____ Sex: M / F

Home Phone: _____ Cell Phone: _____

□ check here if you would like to receive periodic per-recorded phone called alerting you to our specials and sales.

Address: _____ City/State/Zip: _____

Email Address: _____ Employer: _____

□ check here if you do NOT want to receive special offers & newletters from us in your email

Social Security Number: _____ Marital Status: _____ Student: □ YES □ NO

Referring/Primary Provider: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Guarantor (if minor): _____ Phone: _____

Sometimes we have an extern, student or practitioner observing one of our providers- are you comfortable having them in the room during your visit? □ YES □ NO

How did you hear about us? □ Provider: _____ □Friend/Family _____
□ Our Website □ Zoc Doc □ Other: _____ □ Ad:_____

Reason for visit: _____

ALLERGIES (please include reaction) _____

Allergic to Latex? ☐ YES ☐ NO Lidocaine? ☐ YES ☐ NO Do you require Antibiotics before dental work? ☐ YES ☐ NO

CURRENT MEDICATIONS AND DOSAGE: Please use a separate page for medications list if necessary.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current creams/lotions/naturopathic medications: _____

Are you currently taking Aspirin? ☐ YES ☐ NO Motrin, Ibuprofen, Naprosyn? ☐ YES ☐NO

Are you currently taking blood thinners, Coumadin, or Warfarin? ☐YES ☐NO

Please list any minor or major surgeries and/or hospitalizations you have had (including gallbladder, appendix, tonsils, etc.): _____

Health History: Current or past health problems	**YES**	**NO**	**Explain:**
Eczema/Atopic Dermatitis	___	___	_____
Hay fever	___	___	_____
Psoriasis	___	___	_____
Skin Cancer (type & location)	___	___	_____

Eye problems/disorders	___	___	_____
Ears, Nose, or Throat problems/disorders	___	___	_____
Health History: (Continued)	**YES**	**NO**	**Explain:**
Gastrointestinal disease/problems	___	___	_____
Diabetes (type)	___	___	_____
Pacemaker	___	___	_____
Stroke/ TIA's	___	___	_____
COPD	___	___	_____
High Blood Pressure	___	___	_____
Asthma or other lung disease	___	___	_____
Irregular Menstrual Cycles	___	___	_____
Scarring- Keloids	___	___	_____
Blood Borne Disease (HIV/Hepatitis)	___	___	_____
Canker sores or cold sores	___	___	_____
Anxiety or Depression	___	___	_____

Family History (mother, father, paternal/maternal grandparents, siblings)	**YES**	**NO**	**Explain?**
History of Melanoma	___	___	_____
History of Skin Cancer (type & location)	___	___	_____
History of Asthma, Hay Fever, Eczema or Psoriasis	___	___	_____

Fitzpatrick Scale (how your skin reacts to sun exposure) circle one:

Burn Usually Burn Sometimes Burn Rarely Burn Never Burn

Do you have a history of tanning in tanning bed? ☐ YES ☐ NO if yes, frequency: _____

Do you use Tobacco? ☐ YES ☐ NO if yes, amount per day and type:_____

Do you drink Alcohol? ☐ YES ☐ NO if yes, amount per day and type: _____

Do you live alone? ☐ YES ☐ NO

Are you interested in learning more about cosmetic services offered? ☐ YES ☐ NO

Cancellation Policy: We require 24 hour notice of cancellations. We will charge you $25 for any missed appointments ($100 for surgeries). If you miss 3 appointments, you will be prohibited from continuing care at our office.

Financial Policy: Your copay is due at time of service. You are responsible for all charges incurred, whether or not your insurance covers them. As a courtesy we bill your insurance company prior to billing you. Payments are due upon receipt of your first statement. If we do not receive payment we will send one more statement. If there is not a timely response then your account may be referred for third-party collection action. If you are having surgery please be aware that there may be a facility fee billed to your insurance in addition to the professional fees billed to your insurance.

Consent to take photos: I hereby consent to photographs taken of me by my physician. I understand photographs may be used as part of my medical record, and may be used by my physician for medical research or teaching when my physician deems it appropriate.

I certify the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____