Aesthetic and General
Dermatology of Seattle
Elie Levy MD & Associates

13610 First Avenue South
Burien, WA 98168

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We are concerned with your privacy rights. We are complying with national guidelines (HIPAA) to safeguard your personal health information.

We keep a record of the healthcare services we provide to you. You may ask to view and/or obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or receive more information about it by contacting our privacy officer or any front office staff member.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

______________________________	______________________________	
Patient or legally authorized individual	Date	Time

______________________________	______________________________
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

Cancellation Policy: We require **24-hour notice of cancellations**. We may charge you **$100 for any missed appointments ($250 for surgeries).** If you miss **2** appointments, you may 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 your insurance covers them or not. We do not offer refunds or exchanges for services or products purchased. 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:** ____________________

Patient Information: When registering, please present proof of insurance or Medicare card. Payment is due at the time of service.

Please complete all forms and return it to the Front Desk.

Name: ______________________ DOB: __________ Age: ______ Sex: M / F
Home Phone: ______________________ Cell Phone: ______________________

Preferred method of contact: ☐ HOME PHONE ☐ CELL PHONE ☐ US MAIL ☐ EMAIL (Patient Portal)

Is it okay to leave detailed messages? ☐ YES ☐ NO

Address: ______________________ City/State/Zip: ______________________
Seasonal Address: ______________________ City/State/Zip: ______________________
Start Date: __________ End Date: __________

Email Address: ______________@__________
Employer: ______________________ Marital Status: ________ Student: ☐ YES ☐ NO

Emergency Contact/Relationship: ______________________ Phone: __________

Guarantor (if minor): ______________________ Phone: __________
Relationship: ______________________ Date of Birth: __________

If you wish to have medical information disclosed in your absence (results, appointment information, etc.) list below:

Name: ______________________ Relationship: ______________________

Services Offered:

We offer comprehensive dermatological care, providing the newest innovations in treatments, therapies and select research opportunities for our patients who qualify.

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

Research:

✓ Can Dermatology of Seattle contact you about participation in research? *You always retain the right to decline participation in any study.*	☐ YES	☐ NO
✓ Would you allow Dermatology of Seattle to access your medical information to see if you are a good fit for a research trial?	☐ YES	☐ NO
✓ If you would like to participate in dermatological research, what are the best ways to reach you?	☐ CELL ☐ EMAIL	☐ HOME ☐ MAIL

Patient contact, provider & pharmacy details

Additional Medical Information:

Referring Provider/Clinic: ______________________________ Phone: _________________________________

Primary Provider/Clinic: ________________________________ Phone: _________________________________

Pharmacy Name: _________________________________ Location: _______________________________

Preferred Language: ☐ Decline to specify ☐ English ☐ Spanish ☐ Other, ________________________

Race: ☐ Decline to specify ☐ White ☐ American Indian or Alaska native ☐ Asian

☐ Black or African American ☐ Other, ______________________

Ethnic Group: ☐ Decline to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

History and Intake Form

Past Medical History: (please circle all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- High Blood pressure
- HIV/AIDS
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- ☐ **NONE**

Other: ____

Past Surgical History: (please circle all that apply)

- Appendix Removed
- Bladder Removed
- Breast Biopsy
- Lumpectomy (Right, Left, Both)
- Mastectomy (Right, Left, Both)
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Colon: Colostomy
- Gallbladder Removed
- Heart: Biological Valve Replacement
- Coronary Artery Bypass
- Heart Transplant
- Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement, Hip (Right, Left, Both)
- Joint Replacement, Knee (Right, Left, Both)
- Kidney Biopsy
- Kidney Stone Removal
- Kidney Transplant
- Kidney (Nephrectomy)
- Liver Removed (Hepatectomy)
- Liver Transplant
- Liver Shunt
- Ovaries (Oophorectomy) Endometriosis
- Ovaries (Oophorectomy) Ovarian Cancer
- Ovaries (Oophorectomy) Ovarian Cyst
- Pancreas removed
- Prostate Biopsy
- Prostate Cancer
- TURP (Prostate Removal)
- Rectum: APR removed, resection
- SKIN: Basal Cell Carcinoma
- Melanoma
- Skin biopsy
- Squamous cell cancer
- Spleen Removed
- Testicles Removed (Right, Left,)
- Hysterectomy: Uterine Cancer
- Hysterectomy: Cervical Cancer
- ☐ **NONE**

Other: ____

Patient Initials: ________
Date of Birth: ______/_______/_______

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Cancer
Blistering Sunburns	Melanoma	☐ **NONE**

Other: ____________________

Do you wear Sunscreen? Yes No
If yes, what SPF? __________

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ____________________

Other Family Medical History (Mother, Father, Siblings)
____
____

Medications: (Please enter all current medications) ☐ **NONE**
☐ **Check here if you consent for us to import your RX history**
____
____
____
____
____

Drug Allergies: (Please enter all allergies and **reactions**) ☐ **NONE**
____
____
____

Social History: (Please circle or fill in)

Tobacco Use: Current Former Never

Occupation: ____________________

Patient Initials: _________

REVIEW OF SYSTEMS (please circle all that apply)

Problems with bleeding
Problems with healing
Problems with scarring
Rash
Immunosuppression
Hay fever
Chest pain
Fever or chills
Night sweats
Unintentional weight loss
Thyroid problems
Sore throat
Blurry vision
Abdominal pain
Bloody stools
Bloody urine
Joint aches
Muscle weakness
Neck stiffness
Headaches
Seizures
Cough
Shortness of breath
Wheezing
Anxiety
Depression

☐ **NONE**

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Allergy to latex
Artificial heart valve
Artificial joint within the past 2 years
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?
HIV
Hepatitis B
Hepatitis C
Have a history of Melanoma: YES/NO

☐ **NONE**

Patient Initials: ________