SHADES VALLEY
DERMATOLOGY

Name: _____ Sex: _____ DOB: _____
Address: _____ City: _____ Zip code: _____
Social Security Number: _____ Best contact number: _____
Email: _____ Place of employment: _____
Primary physician: _____

Pharmacy name, address, and phone number: _____

Emergency contact name and phone number: _____

How did you hear about our office? _____

What is the reason for today's visit? _____

INSURANCE:

	Insurance Company	Contract Number/Member ID	Group Number	Subscriber Name	Subscriber DOB
Primary					
Secondary					
Tertiary					

MEDICAL HISTORY:
Current medications: _____
Medication allergies: _____
Other allergies including latex, topical medications, adhesives, or surgical dressings: _____
Past surgeries: _____
Have you ever had skin cancer or pre-cancer? Y or N
If yes, which type? Actinic Keratosis (precancer), Basal Cell, Squamous Cell, Melanoma, Dysplastic Nevus, Other
What type of treatment did you receive? _____
Location of cancer or precancer: _____

Are you pregnant? Y or N Are you nursing? Y or N

FAMILY HISTORY:

(Has a blood relative ever had one of the following? Please list the relation.)

Melanoma: Other type of skin cancer:

SOCIAL HISTORY:

Marital Status: (please circle) Single/Married/Widowed

Do you or have you ever: (please circle)

- Use illicit drugs? Y or N
- Use tobacco products? (please circle one): Never/Used to but quit/Every day/Occasionally
- Drink alcohol? Y or N

Race: _____
Ethnicity: _____
Language: _____

SHADES VALLEY
DERMATOLOGY

MEDICAL CONDITIONS:

(If you have any past or current medical conditions that you have been diagnosed with, please check next to the appropriate condition and provide a brief explanation for each, if applicable.)

___ Acne
___ Allergies or sensitivity to local anesthesia including epinephrine
___ Alopecia (Hair loss)
___ Anxiety/Depression
___ Artificial heart valve
___ Asthma
___ Atopic Dermatitis (Eczema)
___ Atrial fibrillation
___ Autoimmune diseases (Rheumatoid arthritis, Sjögren's syndrome, Crohn's disease, ulcerative colitis)
___ Blood clots
___ Blood thinners or anticoagulants (Aspirin, Plavix, Coumadin, Eliquis)
___ Chronic kidney or liver disease
___ Chronic Obstructive Pulmonary Disease (COPD)
___ Cold sores
___ Coronary artery disease
___ Diabetes
___ Elevated blood pressure/Hypertension
___ End-stage renal disease (ESRD)
___ Gastroesophageal reflux disease (GERD)
___ Hepatitis
___ History of immunosuppressive medications (Biologics, Corticosteroids)
___ History of tuberculosis or positive TB test
___ HIV/AIDS
___ Hypercholesterolemia (high cholesterol)
___ Hyperhidrosis (excessive sweating)
___ Joint replacement
___ Keloid formation or hypertrophic scarring
___ Lupus or other autoimmune skin diseases
___ Nail disorders
___ Organ transplant recipient
___ Pacemaker
___ Psoriasis
___ Recent fever or shortness of breath
___ Rosacea
___ Shingles (Herpes Zoster)
___ Skin grafts or prior reconstructive surgery
___ Thyroid disorders
___ Trouble healing
___ Urticaria (hives)
___ Vitiligo

SHADES VALLEY
DERMATOLOGY

- I consent to the necessary treatment of diagnostic tests/procedures including medications, performance of operations, and conduct of studies that may be conducted by Dr. Flanagan and Shades Valley Dermatology staff.
- I understand that Shades Valley Dermatology requires a minimum of 24 hours' notice for appointment cancellations or rescheduling. Failure to provide advance notice or missing an appointment without prior communication will result in a **$50 missed appointment fee**. This policy ensures that we can accommodate other patients in need of care.
- I understand that if I am uninsured or have insurance that is not accepted at Shades Valley Dermatology, I will be responsible for payment IN FULL at the time of service.
- I understand insurance copays, deductibles and charges not filed with insurance are due at the time of service.
- AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.
- You agree, that for us to service your account or to collect monies you may owe, Shades Valley Dermatology and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic dialing device, as applicable.
- I understand that I will be responsible for ANY charges that are not paid by my insurance company. Not all services are covered and I understand that is my responsibility to know the limits of my coverage and to pay any fees that my insurance company denies. (As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask that you pay in full at your visits and file your claims.) I understand that most procedures fall under major medical therefore, I will be responsible for paying the deductible amount at the time of service. Procedures include treatment of skin lesions (including warts, molluscum, moles, skin tags, precancers, and skin cancer) by ANY method (including freezing, biopsy, and in-office application of medication.)
- I understand that for those experiencing financial hardship or unable to pay in full at the time of service, we may offer payment plans and financial assistance options. Please contact our billing office to discuss available arrangements and determine the best solution for your needs.
- I understand that Shades Valley Dermatology may take clinical photographs for medical documentation, including tracking treatment progress and accurately identifying biopsy locations. These images may also be used for educational purposes within the practice. By signing this form, I acknowledge and consent to the use of clinical photography for these purposes.
- I understand that Shades Valley Dermatology provides a range of medical treatments, each of which may involve potential risks and side effects. By signing this form, I acknowledge that I have been informed of these risks, have had the opportunity to ask questions and consent to proceed with treatment as recommended by the provider.
- I authorize the release of medical information to my primary care or referring physician, to consultations if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize the payment of medical benefits to the physician.
- I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or any related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original request for payment of medical insurance benefits either to myself or the party who accepts the assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for the treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.)
- I am aware that the practice has a Notice of Privacy Policies that contains a section on Patient Rights. I have been allowed to review this notice.
- I understand that all messages left for Shades Valley Dermatology will be returned within **24 hours during normal business hours**. To ensure efficient communication and avoid redundancy, we kindly ask that you leave only one message regarding your inquiry.

Patient or Responsible Party Signature:_____ **Date:** _____

Patient Authorization

To ensure the quality of the services/treatment we provide you, please be advised that post-operative care information may be disclosed to the individual accompanying you on the date of your services.

I give Shades Valley Dermatology permission to disclose my medical and financial information to only the individuals listed below:

Name	Relationship to Patient	Phone Number