ARIZONA SKIN INSTITUTE (623) 225-7546

13760 N 93rd Ave, Ste 111
Peoria, AZ 85381

14239 W Bell Rd, Ste 203
Surprise, AZ 85374

DEMOGRAPHICS

Name: _____ Nickname: _____ Date of birth: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Address: _____ City:_____ Zip: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Other: _____ Ethnicity: ☐ Hispanic

Email: _____
☐ Opt out from receiving emails for special events or discounted cosmetic procedures

Primary Care Physician _____ Phone #: (_____)_____-_____
Did this doctor refer you? ☐ Yes ☐ No | If no, how did you find out about us? ☐ Clipper ☐ Newspaper ☐ Email ☐ Valupak
☐ Friend: _____ ☐ Other: _____

Preferred Pharmacy
Name: _____ Phone #: (_____)_____-_____

Cross streets: _____

RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, consent to the release of protected health information that is required to carry out treatment, payment of healthcare operations on my behalf. I have read the **Notice of Privacy Practices** and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I have the right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand the Arizona Skin Institute must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- The Arizona Skin Institute has reserved the right to change from time to time its privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you by placing the amendment date at the bottom of the posted Notice.

I understand that the Arizona Skin Institute may contact me concerning health matters. On these occasions I give my permission to:

Leave a message on my home phone	YES	NO
Leave a message on my cell phone	YES	NO
Speak to another authorized party	YES	NO

Name of authorized party: _____ Date of Birth: _____

OFFICE POLICIES

- Payment is due at the time of service if you have no insurance and/or no insurance referral.
- If you are unable to pay at the time of service, you need to make arrangements with the billing department prior to your visit.
- Co-Insurance and/or co-payment, along with any deductibles, are due at the time of service.
- Please present current ID card when making payments with a check. Arizona Skin Institute will not accept "starter" checks. The check must have your printed name and address on it. *Checks returned by your bank for insufficient funds will cause your account to be assessed a $25.00 fee*.
- Please present your current insurance card at every visit.
- To complete disability and/or cancer insurance form(s) (other than the standard health insurance forms) we will charge a fee of **$25.00 per form**.
- A **"no show" fee of $25.00** may be assessed for appointments not cancelled 24 hours in advance.
- You will be billed for any pathology or blood test not performed in our office. The bill will come from the outside lab facility providing the service. Some of the charges may be an out-of-pocket expense for you.
- Please allow **48 hours** for prescription refill requests to be completed. Please note that we will not fill or refill any prescriptions for controlled substances. Please allow **24 hours** for all phone messages to be returned
- A fee of 35% will be assessed in addition to the amount owed if your account is sent to collections
- In order for us to service your account or to collect any amounts you may owe, we may contact you by telephone using 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 e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device.

I understand and agree to the consent for releasing my protected health information and office policies for the Arizona Skin Institute.

_____	
Signature of Patient or Legally Authorized Representative	*Signature of Witness*
_____	Anna Del Valle
Printed Name of Patient or Legally Authorized Representative	*Printed Name of Witness*
_____	_____
Description of Legal Authority	*Date*

Medications (ALL prescriptions, over the counters, vitamins, herbal supplements with dosages/how often)

Name	Dose	How often?	What condition do you take this for?

Aspirin? ☐ Yes ☐ No | *Blood thinners?* ☐ Yes ☐ No | *Fish oil/vitamin E?* ☐ Yes ☐ No

Flu vaccine within last year? ☐ Yes ☐ No/refused | Pneumonia vaccine within last five years? ☐ Yes, year? _____ ☐ No/refused

Past Medical History ☐ No significant medical history

- ☐ Malignant melanoma
- ☐ Squamous cell carcinoma (SCC)
- ☐ Basal cell carcinoma (BCC)
- ☐ Atypical nevi (abnormal moles)
- ☐ Unknown skin cancer
- ☐ Acne
- ☐ Actinic keratosis (precancerous spots)
- ☐ Allergies/hay fever
- ☐ Dry Skin
- ☐ Eczema
- ☐ Hives
- ☐ Lupus
- ☐ Psoriasis
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/clotting disorder
- ☐ COPD
- ☐ Diabetes Type ☐ 1 ☐ 2
- ☐ Depression
- ☐ End stage kidney disease: ☐ Dialysis
- ☐ Glaucoma
- ☐ GERD (acid reflux)
- ☐ Hepatitis: ☐ B ☐ C, treated? ☐
- ☐ Hearing loss/deaf
- ☐ Heart attack
- ☐ Heart valve abnormal
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Irregular heart beat (atrial fibrillation)
- ☐ Keloids (scars)
- ☐ Leukemia/lymphoma
- ☐ Liver disease
- ☐ Migraines
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid: ☐ Low ☐ High
- ☐ Cancer (type): _____
- ☐ Other: _____

Drug Allergies ☐ No known drug allergies

Name	Anaphylaxis	Angioedema	Liver toxicity	GI Upset	Hives/rash	Other
_____	☐	☐	☐	☐	☐	☐ _____
_____	☐	☐	☐	☐	☐	☐ _____
_____	☐	☐	☐	☐	☐	☐ _____
Lidocaine	☐	☐	☐	☐	☐	☐ _____
Epinephrine	☐	☐	☐	☐	☐	☐ _____
Adhesive/Tape	☐	☐	☐	☐	☐	☐ _____
Latex	☐	☐	☐	☐	☐	☐ _____

Past Surgical History ☐ No significant surgeries

Heart
- ☐ Defibrillator ☐ Pacemaker
- ☐ Coronary Artery Bypass Surgery (CABG)
- ☐ PTCA
- ☐ Mechanical/biological valve replacemant

Breast
- ☐ Mastectomy: ☐ R ☐ L ☐ Both
- ☐ Lumpectomy: ☐ R ☐ L ☐ Both
- ☐ Reduction: ☐ R ☐ L ☐ Both
- ☐ Implants: ☐ R ☐ L ☐ Both

Orthopedics
- ☐ Knee replacement: ☐ R ☐ L ☐ Both
- ☐ Hip replacement: ☐ R ☐ L ☐ Both

General
- ☐ Appendix removed
- ☐ Bladder removed
- ☐ Colon removed: ☐ R ☐ L ☐ Total
- ☐ Gallbladder removed
- ☐ Kidney removed: ☐ R ☐ L
- ☐ Kidney stone removed
- ☐ Ovary removed: ☐ R ☐ L ☐ Both
- ☐ Prostate removed: ☐ TURP
- ☐ Spleen removed
- ☐ Testicles removed: ☐ R ☐ L ☐ Both
- ☐ Uterus removed: ☐ Partial or ☐ Total

Transplant
- ☐ Bone marrow transplant
- ☐ Heart transplant
- ☐ Liver transplant
- ☐ Kidney transplant
- ☐ Other: _____

Skin Cancer Location	Melanoma	Basal	Squamous	Unknown	Mohs
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Family History ☐ No significant family history

Name	Father	Mother	Brother	Sister	Son	Daugtr	Other blood relative
☐ Malignant melanoma	☐	☐	☐	☐	☐	☐	☐ _____
☐ Squamous cell carcinoma (SCC)	☐	☐	☐	☐	☐	☐	☐ _____
☐ Basal cell carcinoma (BCC)	☐	☐	☐	☐	☐	☐	☐ _____
☐ Atypical nevi (abnormal moles)	☐	☐	☐	☐	☐	☐	☐ _____
☐ Unknown skin cancer	☐	☐	☐	☐	☐	☐	☐ _____
☐ Actinic keratosis (precancerous spots)	☐	☐	☐	☐	☐	☐	☐ _____
☐ Hypertension	☐	☐	☐	☐	☐	☐	☐ _____
☐ Diabetes	☐	☐	☐	☐	☐	☐	☐ _____

Social History

Did you drink alcohol in the last year? ☐ No ☐ 1 or less per month ☐ 2-4 times per month ☐ 2-3 times a week ☐ 4+ times a week
Drinks each time? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10+ drinks

Do you smoke/use tobacco? ☐ Currently everyday _____ packs per day ☐ Current some day smoker
☐ Former smoker, quit in the year _____ ☐ Never smoked

Do you use recreational drugs? ☐ None ☐ IV drug use

What is your caffeine use? ☐ Never ☐ Few times a month ☐ Few times a week ☐ Daily

How often do you exercise? ☐ Never ☐ Few times a month ☐ Few times a week ☐ Daily

Tanning beds? ☐ No ☐ Yes, how often? _____

Spend time outdoors? ☐ No ☐ Yes, how often? _____

Wear sunblock/sun-protective clothing? ☐ No ☐ Yes SPF? _____

ARIZONA SKIN INSTITUTE

Women

Are you pregnant or actively trying to become pregnant? ☐ Yes ☐ No Due Date: _____

Are you breast feeding? ☐ Yes ☐ No

Please check off any of the following symptoms that you have at present: ☐ None of the following apply

☐ Immune suppressed	☐ Chronic cough	☐ Joint aches
☐ Recent unintentional weight loss/gain	☐ Frequent significant fatigue	☐ Leg swelling
☐ Need antibiotics before surgery	☐ Breathing problems	☐ Eye problems
☐ Yeast infection from antibiotics	☐ Recurrent mouth sores	☐ Headache
☐ Sun sensitivity	☐ Fever/chills	☐ Dizziness

Cosmetic Questionnaire (optional)

Check off all those that interest you:

☐ Anti-aging skin rejuvenation
☐ Skin care products/sunscreen
☐ Acne scars/blackheads
☐ Age/brown spots
☐ Enlarged oil glands
☐ Flushing/redness
☐ Fine lines/wrinkles
☐ Spider veins

Check off areas of concern:

☐ Forehead
☐ Frown lines
☐ Crow's feet
☐ Dark circles
☐ Vertical lip lines
☐ Nose-to-mouth lines (parentheses)
☐ Marionette lines