Grace Dermatology
& Micrographic Surgery

2500 S Main Rd, Lebanon, OR 97355 Phone: (541) 258-SKIN (7546) Fax: (541) 570-1744

Patient Information

How did you hear about Grace Dermatology/Dr. Horner?_____

Last Name_____ First Name_____ M.I._____

Prefer to be called (or Nickname)_____

Date of Birth_____/_____/_____ Age_____ SSN_____-_____-_____ ☐ Male ☐ Female

Mailing Address_____ City_____ ZIP_____

Best Phone #_(_____)_____ Alternate_(_____)_____ Work_(_____)_____

E-Mail_____ Occupation_____ ☐Retired

Referring Provider_____ Primary Care Provider_____

Guardian (if minor patient) Last _____ First _____ M.I.___ DOB_____

*Required demographic information (for the patient being seen): ☐ Single ☐ Married ☐ Minor

Preferred Language: ☐ English ☐ Other_____

Race: ☐White ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino ☐Yes ☐No ☐ Prefer not to Answer

May we leave personal medical information on your answering machine/cell phone? ☐ YES ☐ No

Do you give our office permission to discuss your medical condition with family members? ☐ YES ☐ No

If Yes, please list below (Primary or Emergency Contact first):

Name_____ Relationship_____ Phone_(_____)_____

Name_____ Relationship_____ Phone_(_____)_____

***Insurance Information** (Our front desk will also scan your insurance cards at check-in)

Primary Insurance_____Group#_____ID#_____
Policy Holder Name (as it appears on the card):_____
Relationship_____ DOB_____

Secondary Insurance _____Group #_____ID#_____
Policy Holder Name (as it appears on the card):_____
Relationship_____ DOB_____

TREATMENT AUTHORIZATION: I voluntarily consent to receive medical care and services provided by, or at the direction of, Dr. Horner. I authorize a copy of this document to be used in place of the original. If the patient is a minor, I give permission for the patient to receive future follow-up care from the physician and staff at Grace Dermatology in my absence.

Signature of Patient (or Legal Guardian)_____ Date_____

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Reason for your visit today? _____

Past Medical History (please check all that apply):

☐ Anxiety ☐ Arthritis ☐ Asthma

☐ Atrial Fibrillation ☐ Bone Marrow Transplant ☐ Cancer (type)_____

☐ COPD ☐ Coronary Artery Disease ☐ Depression

☐ Diabetes ☐ End Stage Kidney Disease ☐ Hearing Loss

☐ Heart Attack ☐ Hepatitis (type)_____ ☐ High Blood Pressure

☐ HIV/AIDS ☐ Pacemaker ☐ Radiation Treatment

☐ Seizures ☐ Stroke ☐ Hyperthyroid ☐ Hypothyroid

Other_____ ☐ None

Past Surgical History (please check all that apply):

☐ Mechanical Heart Valve Replacement ☐ Biological Heart Valve Replacement

Organ Transplant (☐ Heart, ☐ Lung, ☐ Liver, ☐ Kidney, ☐ Other_____)

Joint Replacement within the last 2 years: ☐ Knee (☐ Right, ☐ Left, ☐ Both, year_____)

☐ Hip (☐ Right, ☐ Left, ☐ Both, year_____)

☐ Skin Biopsy ☐ Skin Cancer surgery ☐ Spleen Removed Other_____ ☐ None

Skin Disease History (please check all that apply):

☐ Acne ☐ Actinic Keratoses (AK's) ☐ Atypical/dysplastic Moles

☐ Basal Cell Carcinoma (BCC) ☐ Blistering Sunburns ☐ Dry Skin

☐ Eczema ☐ Flaking or Itchy Scalp ☐ Hayfever/Seasonal Allergies

☐ Melanoma ☐ Poison Oak ☐ Psoriasis

☐ Squamous Cell Carcinoma (SCC)

Other_____ ☐ None

Do you wear sunscreen? ☐ Yes ☐ No; If Yes, what SPF?_____ Do you use a tanning bed? ☐ Yes ☐ No

Do you have a family History of Melanoma? ☐ Yes ☐ No; Non-Melanoma Skin Cancers? ☐ Yes ☐ No

If Yes, which relatives:_____

Social History (please check all that apply): Smoking: ☐ Never ☐ Occ. ☐ Daily ☐ Quit, when_____

Alcohol: ☐ None ☐ less than 1 drink a day ☐ 1-2 drinks a day ☐ 3+ drinks a day

Height_____ Weight_____ Initials_____ Date_____

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Allergies: (Please list all allergies and the reaction. For example: Penicillin – Rash or Latex – Anaphylaxis)

_____

_____

Medications: Please list all current medications (including OTC's) with dosage and timing instructions. For example: Aspirin 81mg daily. (We will also gladly accept a detailed list.)

Circle if you take: Aspirin; Ibuprofen (Motrin, Advil); Naprosyn (Aleve); Fish Oil/Omega 3; Vitamin E

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Your PHARMACY (name & location)_____

Review of Systems: (Check any that apply to you currently):

☐ Pacemaker ☐ Defibrillator ☐ Artificial Heart Valve ☐ History of Endocarditis

☐ Artificial joints within 2 yrs ☐ Blood thinners ☐ Diabetes ☐ Organ transplant ☐ Immunosuppression

☐ Premedication prior to procedures ☐ Pregnancy or planning pregnancy ☐ Problems with bleeding

☐ Problems with healing ☐ Problems with scarring (hypertrophic or keloid) ☐ Allergy to adhesive

☐ Allergy to topical antibiotics ☐ MRSA ☐ Rash ☐ Chest pain ☐ Fever or chills ☐ Night sweats

☐ Unintentional weight loss ☐ Thyroid problems ☐ Sore throat ☐ Blurry vision ☐ Abdominal pain

☐ Bloody stool ☐ Joint aches ☐ Headaches ☐ Seizures ☐ Shortness of breath ☐ Anxiety ☐ Depression

Photos will be taken for your medical record. I consent to show these photos for medical teaching ONLY and as long as my name and other forms of personal identification are not shown. ☐ No ☐ Yes

Financial Policy and authorizations: As a courtesy, we will bill your insurance for you, but you are ultimately responsible for understanding your insurance coverage and you are responsible for paying your co-pay, deductible, co-insurance, non-medical (cosmetic) charges, or charges not covered by your insurance at the time of service or promptly, when billed. We reserve the right to charge a reasonable fee for missed appointments ("no-show" visits). If your account is not paid in a timely manner and it is turned over to a collections agency, you will be financially responsible for any collection fees incurred by our office. I hereby assign all applicable benefits and direct that payment be made to Grace Dermatology for all services provided to/for me during my visits. I authorize Grace Dermatology to furnish medical and other information necessary to process claims on my behalf. This information may be released to my personal physician or other health care providers as requested for continuity of care. This release of information will remain in effect until revoked by me in writing.

NOTICE OF PRIVACY PRACTICES: As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by Grace Dermatology.

Signature of Patient (or Legal Guardian)_____ Date_____