PHOEBE RICH DERMATOLOGY
Oregon Dermatology & Research Center

Registration - Phoebe Rich Dermatology

Patient Information

First | Middle | Last Name | Preferred Name & Pronouns | Date of Birth | Today's Date

Mailing Address | City, State, Zip Code

Preferred phone ☐ Cell ☐ Work | Secondary phone ☐ Cell ☐ Work | Patient phone number (for minors)

Email address

☐ I would like to be web-enabled to view results, see chart notes, and send messages online.

Name of Family Physician | Phone Number

→ ☐ It is ok to share medical records between my medical providers when possible.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Sex: ☐ Male ☐ Female ☐ Transgender ☐ _____

Employment Status: ☐ Student ☐ Retired ☐ Employed; employer: _____

Preferred Language: ☐ English ☐ Other: _____ Do you require an interpreter? Y / N

Please complete the following for children under 18 years of age:

Parent/Guardian name | Phone number | Parent/Guardian name | Phone number

How were you referred to our office?

☐ By a Doctor ☐ By a Patient Please print the name of your source: _____

Pharmacy Information

Pharmacy: _____ Phone: _____ Street: _____

How Would You Prefer to be Contacted with Procedure Results?

☐ Phone ☐ It is okay to leave a voicemail with medical information ☐ Online through the Patient Portal

List persons we may leave messages with or discuss medical conditions with:

_____

Insurance Information; if your insurance card was scanned in you can skip this section.

Name of Policy Holder | Date of Birth | Relationship to Patient

Insurance Company | Group Number | ID Number

Address | City, State, Zip Code

Over →

Emergency Contact / Caretaker Information (mandatory)

Name	Phone Number	Relationship

Address	City, State, Zip

Employer (if hired caretaker for patient)	Employer Phone Number

If there become recognized cognitive impairments (memory loss, difficulty processing information) that may affect the patient's healthcare management or decision-making, do we have permission to reach out to the above contact? ☐ **Yes** ☐ **No**

If no, please list who we may contact in this situation:

Name	Phone	Relationship

Consent to Treatment

Permission is given to Phoebe Rich Dermatology and staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. We will be happy to discuss your concerns at any time. During your visit your health and safety are our main concern. We usually recommend a full skin examination for patients who are new to our office to search for and document benign and potentially malignant skin lesions. You can opt out of a full skin examination if you wish, but we recommend it at least once a year, especially if you have had a previous skin cancer. If a suspicious appearing or concerning skin lesion is discovered, a biopsy or surgical excision may be recommended. As with all medical and surgical procedures there are risks of scarring, infection at the surgical site, bleeding, allergic reaction to anesthesia, acute or chronic pain, and slow healing, especially on lower extremities and feet. We always do our best to minimize side effects and scarring, but scars and keloids can occur, and are more likely with removal of large skin cancers on the upper torso and face, even under the best surgical conditions. We want you to ask any and all questions that you may have regarding your skin treatment and surgical procedures, especially about the risks and alternative treatments that may be available, and we hope you will not hesitate to inquire. Our goal is to provide the very best care possible for your skin conditions, and to work together with you as a team to assure your skin health.

Financial Responsibility and Assignment of Benefits

☐ I **am** supplying Phoebe Rich Dermatology with insurance information. I authorize my insurance company to pay directly to Phoebe Rich Dermatology all benefits due for my medical care, and hereby consider this an assignment of benefits. I authorize Phoebe Rich Dermatology to provide all information my insurance company requests concerning my treatment. If my insurance company requires a referral from my primary care physician and I did not obtain a referral prior to my appointment, I am financially responsible for all services. It is understood that I am financially responsible for all services not covered or allowed by my insurance company, including out of office services such as pathology services and lab testing (including deductibles and co-pays). Any money received in excess of my charges will be refunded when my bill is paid in full. I understand that if I do not show up for an appointment, or if I cancel with less than 24 hours notice, I will be charged a $50 fee for a standard appointment or $100 for IPL treatment or surgery.

-OR-

☐ I am **not** supplying Phoebe Rich Dermatology with insurance information. I understand that I am financially responsible for all services performed, due on the date of service. I understand and will comply with the financial policy of Phoebe Rich Dermatology.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person	*Date*