BAKER
ALLERGY · ASTHMA
DERMATOLOGY

Before your first Dermatology appointment:

Please verify that Baker Allergy, Asthma, and Dermatology is in network with your insurance plan before your appointment date.

If needed, obtain a referral from your primary care physician.

Fill out the New Patient Packet and bring to the clinic for your appointment. Be aware that if you arrive late and/or your paperwork is not complete at the time of your appointment, we may need to reschedule or delay your visit as a courtesy to our other patients.

What You Need to Know for Your Appointment:

Bring in your insurance card or a printout of your card, if you have an electronic version, to your appointment.

The office requires that you provide 24-hour notice to cancel or reschedule appointments.

If you have any questions, please give us a call at **503-636-9011**.

We are located at:
9495 SW Locust Street, Suite A
Portland, OR 97223

Baker Dermatology Medical History Intake

Patient Name: **Date:**

Past Medical History

(please circle what conditions you have) **Date Of Dx**

Diabetes _____
Hypothyroid/Hyperthyroid: _____
Anxiety/Depression: _____
High Blood Pressure: _____
Autoimmune disease (Please List): _____
HIV/AIDS, Hepatitis C: _____
GI Issues/ Ulcerative Colitis/ Crohn's: _____
Cancer - Type/Date/Treatment (**NOT** skin cancer):

****Please bring to your appointment a list of all medications/ supplements that you are currently taking****

Female Patients: Pregnant Yes / No Breastfeeding: Yes / No

Smoker: Yes / No

If Yes, how many packs per day? _____

Prior Tobacco Use: Yes / N Years: _____

Skin Cancers (list body site and date)

Actinic Keratoses (pre-cancerous lesions)

Basal Cell:

Squamous Cell:

Atypical Mole:

Malignant Melanoma:

Family History of Malignant Melanoma:

Family History of Other Skin Cancers:

Skin Disorders: (Please circle) **Date of Dx:**

Acne/Rosacea: _____
Seborrheic Dermatitis/dandruff/Hair loss: _____
Excessive Sweating -Hands/Feet/Axilla: _____
Eczema/Seasonal Allergies/Asthma: _____
Psoriasis/Psoriatic Arthritis: _____
Herpes - Cold Sore/Genital/Shingles: _____
Hypertrophic / keloid scars: _____
Other Skin Disorders (Please List): _____

Surgical History: (please list) **Dates:**

Other Surgical Problems: If yes, please explain

Bleeding Problems: Yes / No
Anesthetic Problems: Yes / No

Pertinent Family Medical History: **Who?**

Autoimmune Diseases:
Acne / Rosacea
Cancer (other than skin cancer)
Eczema/ Seasonal Allergies/ Asthma
Psoriasis/ Psoriatic Arthritis
GI issues/ Ulcerative Colitis/ Crohn's

Social History

Occupation:_____
Married: Yes / No
Children: Yes / No How Many_____

Sun Exposure History:

Do you regularly use sunscreens: Yes / No What SPF?
Do you use tanning beds : Yes / No Tanned in the Past: Yes / No
History of sunburns with blistering? Yes / No

Primary Care Physician: **Phone:**

Preferred Lab (Does your insurance company mandate a specific lab for your tests?):

Preferred Pharmacy: **Phone:**

Date Reviewed/ Updated: (Providers only)					

Name: _____ Date: _____

Medications

If you are a new patient, have not been seen in this office in over one year or have new medications since your last appointment please fill out this form.

If you brought a medication list please give it to the receptionist to make a copy.

Please list all of your prescription medications below

Medication name	Dose	Date Started	Condition Medication Is For

Please list all over the counter medication you take including vitamins and supplements

_____

_____

_____

_____

_____

_____

Please list any topical medications you are using that may not be listed above

_____

_____

_____

Medication allergies (including latex):_____

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CHART NUMBER_____ DATE_____ NEW / UPDATED

DEMOGRAPHICS

PATIENT'S FULL NAME:_____BIRTHDATE:_____SEX: M / F

ADDRESS:_____

CITY, STATE, ZIP:_____

OCCUPATION/EMPLOYER:_____

PREFERRED PHONE #1:_____PHONE #2: _____PHONE #3: _____

EMAIL (PLEASE WRITE CLEARLY):_____

SPOUSE (IF APPLICABLE):_____

PREFERRED PHONE: _____OCCUPATION/EMPLOYER_____

IF PATIENT IS A **MINOR**, PLEASE ENTER PARENT/GUARDIAN INFORMATION:

NAME:_____RELATIONSHIP:_____BIRTHDATE: _____

NAME:_____RELATIONSHIP:_____BIRTHDATE: _____

CONTACT AUTHORIZATION

By signing below, I hereby authorize Baker Allergy, Asthma & Dermatology to leave a voicemail regarding visits and any results needing to be communicated at the contact phone numbers provided to us. I also give the authorization to utilize email and/or text to communicate appointment reminders, scheduling messages, health-related newsletters, and clinic updates to the email/mobile devices provided to us. I acknowledge I have the right to opt out of emails/texts at any time.

SIGNATURE AUTHORIZING THE ABOVE STATEMENT:_____
(if patient is a minor, signed by legal parent or guardian)

PRIMARY CARE / REFERRAL

PRIMARY CARE PROVIDER (full name):_____PHONE / FAX:_____

Were you referred to us by a patient or staff member? If so, NAME:_____

Have you or any family members ever been seen at our clinic? If so, NAME:_____

JAMES W. BAKER, MD, LLC
DBA: BAKER ALLERGY, ASTHMA & DERMATOLOGY

PATIENT RESPONSIBILITY FOR PAYMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our business manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Baker Allergy, Asthma & Dermatology will submit charges for medical treatment to the patient's insurance company and where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.

Baker Allergy, Asthma & Dermatology does not verify in advance the patient's insurance. Patients should contact their insurance companies directly for any coverage questions they may have. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay.

If the patient participates in an Oregon Health Plan program, the patient will be responsible for notifying the office at the time of service. If the patient participates in Washington DSHS, the patient will be responsible for all services. Baker Allergy, Asthma & Dermatology does not accept Washington DSHS.

Baker Allergy, Asthma & Dermatology does not treat worker's compensation injuries or illnesses. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit

If the patient participates in a plan that requires co-payment, the patient must pay the co-payment at the time of the appointment.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at Baker Allergy, Asthma & Dermatology for medical care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred.

Patient Responsibility (Disclaimer)

I understand that my insurance plan may require a referral from my Primary Care Physician in order to cover the visits to a Specialty Physician. If Baker Allergy, Asthma & Dermatology at this time has not received verification that a referral was obtained for services, and, if my insurance company denies payment, I agree that I will be financially responsible for any and all charges incurred (including lab and xray).

I hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and the physician to release to the insurance company any information acquired in the course of my examination and treatment.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Baker Allergy, Asthma & Dermatology to release to my insurance company any information acquired in the course of my examination or treatment. I also agree to full responsibility for all expenses incurred by or on account of myself or this patient and hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due to the fullest extent of my financial obligation to said office.

_____ _____

Patient Signature (Parent or Guardian if patient is a minor) Date

_____

Patient Printed Name (or printed name of Parent or Guardian if patient is a minor)

_____

Address of Guarantor

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES YOUR REFERRAL RIGHTS WHEN YOUR HEALTH CARE PROVIDER REFERS YOU TO ANOTHER PROVIDER OR FACILITY FOR ADDITIONAL TESTING OR HEALTH CARE SERVICES.

In accordance with Oregon law, when you are referred for care outside of our clinic, we at Baker Allergy, Asthma & Dermatology, are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.
- A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
  (a) That when referred, a patient has a choice about where to receive services; and
  (b) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;
- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.
- _____
- **By signing below, I acknowledge that I <u>have read and understand my referral rights</u> as outlined above.**

_____ _____
Patient Signature Date

_____
Print Patient Name

-OR-

_____ _____
Parent, Guardian, Responsible Party, Legal Representative Signature Date

_____
Description of Representative's Authority

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have access to a copy of the

BAKER ALLERGY, ASTHMA & DERMATOLOGY

Notice of Privacy Practices

By signing below, I agree that I have access to a copy of the Notice of Privacy Practices through the website and through hard copies conveniently located in the lobby of the clinic.

_____ _____
Patient Signature Date

_____
Print Patient Name

-OR-

_____ _____
Parent, Guardian, Responsible Party, Legal Representative Signature Date

_____
Description of Representative's Authority