Susan Tobey Denman, MD
Dermatologist
Surgeon
Dermatopathologist

Aloha Dermatology Clinic
18345 SW Alexander Street; Ste B
Aloha, OR 97006
503-649-9477
503-649-1272 fax

Patient Information		
Patient Name:		
Mailing Address:		
Street Address (if different):	**Email Address**:	
Home Phone:	**Cell Phone**:	**Work Phone**:
Date of Birth:	Social Security #:	Primary Care Dr:
Marital Status: (Circle): single married separated divorced widowed partner		Spouse's Name: (if applicable)
Emergency Contact:	**Phone #:**	
Relationship:		
Patient's Occupation:	Employer:	
Pharmacy Name:	**Phone #:**	
Primary Language: (Circle) **English** **Spanish** **Other (specify)** _____		
Race/Ethnicity: (Circle): Asian Native American or Native Alaskan Black or African American Hispanic or Latino Pacific Islander White Prefer not to answer		
RESPONSIBLE PARTY INFO: (This is the person responsible for balances after insurance has addressed your claims)		
Responsible Party:		Phone:
Responsible Party Address:		
Primary Insurance Information		
Insurance:	Phone Number:	
Ins. Address:		
Primary Subscriber information: (This is the person who holds the insurance)		
Subscriber Name:	Date of Birth:	
Subscriber ID:	Group #:	
Secondary Insurance Information		
Insurance:	Phone Number:	
Ins. Address:		
Secondary Subscriber information: (This is the person who holds the insurance)		
Subscriber Name:	Date of Birth:	
Subscriber ID:	Group #:	

Patient Name:

Financial Agreement, Assignment of Insurance Benefits, and Release of Information:

Please read and sign the following consents, release, and agreements:

1. RELEASE OF INFORMATION: to obtain payment for services, the undersigned hereby authorizes the clinic to furnish from the patient's record requested information or excerpts to any insurer, employer, or union which processes claims for the patient's care.
2. PAYMENT AUTORIZATION: I authorize payment directly to Susan Tobey Denman, M.D. of all benefits otherwise payable to me or for my benefit by reason of any insurance policies and I hereby irrevocably assign such benefits to Susan Tobey Denman, M.D. in any amount, however, not to exceed the charges for the service rendered above. I agree to be responsible for charges not covered by insurance. If my indebtedness for such charges is placed with an attorney or agency to collection, I agree to pay Susan Tobey Denman, M.D. reasonable attorney's fees and collection expenses.

X _____ _____
Signature of Patient Date

X _____ _____
Patient or person assuming responsibility (other than patient) Date

Medicare Patient Certification: Authorization to Release Information and Payment Request:

LIFETIME AUTHORIZATION **AUTHORIZATION PERIOD:** **FROM:** **TO:**

"I request that payment under the medical insurance program be made to me or the provider named above on any bills for service furnished to me during the effective period of this authorization, and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original."

X _____ _____
Signature of Patient Date

X _____ _____ _____
Signature of Witness Print Witness Name, Relationship Date

SUSAN TOBEY DENMAN, M.D. *ALOHA DERMATOLOGY CLINIC*

Your Name _____ **Today's Date**:_____

1. HAVE YOU NOTICED ANY NEW OR CHANGING MOLES? Yes___ No_____

*If so, where?*_____

2. PLEASE HELP US ANSWER YOUR QUESTIONS TODAY:

Please write down why you are coming to see Dr. Denman, and any questions or issues you would like to discuss with her.

_____

_____

_____

_____

_____

_____

_____

_____

What treatments have you tried?

_____

_____

_____

_____

_____

List any medications prescribed by Dr. Denman that you need to have refilled:

_____

_____

_____

Please give this page to the receptionist to be entered into your medical record.

SUSAN TOBEY DENMAN, M.D.
ALOHA DERMATOLOGY CLINIC

CONFIDENTIAL MEDICAL HISTORY

Patient Name: _____ Today's Date_____

Date of Birth: _____ Gender: Male ☐ Female ☐

Your Primary Care Dr's full name? _____ In what city? _____

List any serious illnesses you have had, and the dates:

_____

_____

_____

List any surgeries you have had, and the dates:

_____

_____

_____

What is your height? _____ (ft/in) And weight? _____ (lbs)

Do you take aspirin daily? Yes ☐ No ☐ Do you have an Advance Directive? Yes ☐ No ☐

Smoking Status: ☐Current every day smoker ☐Current occasional smoker

☐Former smoker ☐Non smoker with no smoking history

How many alcoholic beverages do you consume weekly? _____

Do you or a family member have a history of:	SELF		FAMILY MEMBER	
	Yes	No	Yes	No
Eczema				
Hay fever				
Asthma				
Allergies				
Malignant Melanoma				
Skin Cancer				
Diabetes				
Heart Disease				
Artificial Heart Valve				
Arthritis				
Artificial Joint				
High Blood Pressure				
Tuberculosis				
Yellow Jaundice/Hepatitis				
Liver Disease				
Drug Allergies				
Bleeding Disorders				
Stomach Ulcers				

List Any Allergies to Drugs:

_____

_____

_____

_____

_____

Please provide details for any medical condition to which you checked 'yes' in the boxes at left:

_____

_____

_____

_____

_____

FOR WOMEN ONLY:

Number of: pregnancies _____

children _____

Are you pregnant? ☐ Yes ☐ No

Patient, Parent, or Caregiver Signature_____

Patient Name_____ DOB _____ Today's Date_____

Patient Medication List

Please include all prescriptions, over-the-counter medications, and supplements.
(You can substitute a separate list, if you brought it with you.)

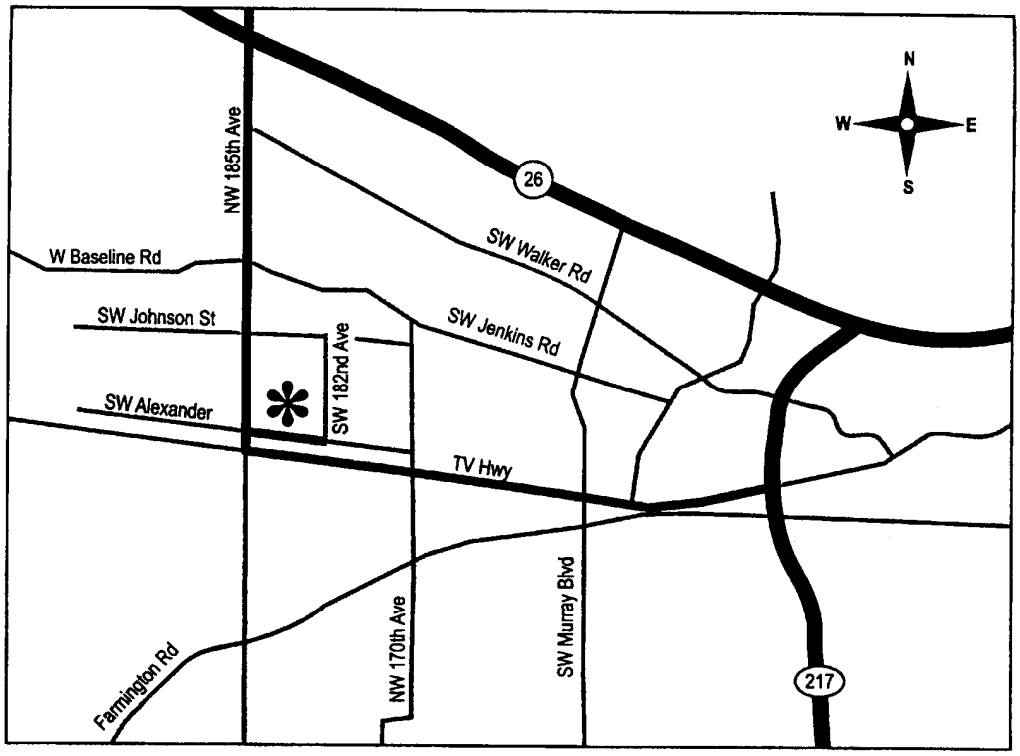
	Medication Name	**Mg** per Tablet or % Strength	**How Many** per Dose?	**How Often** Taken?	**Route** (by mouth, injection, topical?)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					

I give permission for Dr. Denman or her staff to use an electronic prescription service to get information about my current and past medications prescribed by other healthcare providers. Yes ☐ No ☐

Patient, Parent, or Caregiver Signature_____

SUSAN TOBEY DENMAN, M.D.
PHYSICIAN AND SURGEON
DERMATOLOGY

ALOHA DERMATOLOGY CLINIC
18345 S.W. ALEXANDER
ALOHA, OREGON 97006
(503) 649 - 9477



From Highway 26

Take the 185th Avenue exit and turn South on 185th. Follow for approximately 3 miles before turning left on Alexander. Take a left into the fourth driveway; our office is in the second building back on the right.

From Highway 217

Take the Canyon/OR-8 exit and turn West on Canyon. Follow for 3.7 miles (turns into TV Highway). Turn right on 185th Avenue and take your first right onto Alexander. Take a left into the fourth driveway; our office is in the second building back on the right.