Thank you for choosing our Dermatology office! We look forward to making your visit as comfortable and productive as possible. The following steps will help us provide the best use of your time with the provider:

- **Minor Patients:** All minors must be accompanied by a parent/legal guardian at each visit. If not accompanied by parent/legal guardian the appointment may be rescheduled.
- **Please arrive 15 minutes early so we can register/update your information.**
- **Please provide ALL insurance cards, Picture ID, POA and/or current ProviderOne card if applicable:**
  - Current insurance card/s are required by your insurance company to be presented at every visit to our office. Your appointment will be rescheduled to the next available appointment if you do not present all insurance cards at registration.
  - Your insurance company obligates us to maintain a copy of your insurance card in your medical record for the purpose of billing your visit.
- Please refrain from wearing perfume or colognes to our office. Many of our patients have severe allergies, and as a courtesy to them our office is a "scent free" zone.
- Bring your referral, if required. Your insurance company can tell you if you need a referral; we are unable to contact them for you. If your insurance company requires a referral and one is not provided to us, your appointment will be rescheduled.
- Please be prepared to pay your co-pay at the time of check-in if one is required. We charge a $5.00 fee to bill you later for co-pays.
- Please bring in the containers of any medications or over-the-counter products that you are using to treat the current problem.
- Please read entire packet and completely fill out any forms sent to you before arrival.
- Individuals seeking treatment are not considered to have been accepted into the practice and formed a provider-patient relationship until they have completed a face-to-face visit with a provider who has completed an evaluation and assessment.

We recommend you allow plenty of time for your first appointment. This initial visit takes time to register, and we do not want to shorten your time with the provider or have to reschedule your appointment if you are late. Due to the shortage of dermatology providers, your appointment may have been scheduled some time ago, and it may not work with your current schedule. Please call us as soon as you are aware that you need to reschedule. With 24 hours notice, we are happy to reschedule; however the new time might be several weeks later. If you fail to keep your appointment without notifying us in advance, you will not be rescheduled again.

For your convenience, our appointment line is available to take a message 24 hours a day. Please call (360) 292-7700 if you wish to leave a message. You may call us during office hours of 8 a.m. to 5 p.m. Monday through Thursday, or 8 a.m. to 4 p.m. Friday, to reach a receptionist.

**DIRECTIONS:** Please see reverse side.
**TRAVELING SOUTH on I-5, EXIT 105B:**
Head west off Exit 105B, down ramp and travel 0.3 mi. Merge onto Plum St SE. Follow Plum St. to State Avenue, approximately 0.6 mi. Turn left onto State Ave NE and go 0.6 mi. Stay to the right and merge onto 4th Ave W and cross the bridge. At the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. Stay to the right and take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

**TRAVELING NORTH on I-5, EXIT 103:**
Head down the ramp to Deschutes Way SE and remain on this road as it becomes Deschutes Parkway SW. Continue on Deschutes Pkwy SW along the west side of Capital Lake for 1.8mi. Deschutes Pkwy turns into 5th Ave at the junction with the bridge. Travel for 0.1mi. Turn left on Simmons Street NW. Turn left onto 4th Ave W and cross the bridge. Merge into right lane and at the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. In the right lane take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

**TRAVELING EAST on Highway 101:**
Take the Black Lake Blvd exit toward W Olympia. At bottom of ramp turn left onto Black Lake Blvd SW, Travel 1.2mi. Turn right onto Harrison Ave NW and go approximately 0.6mi. As you head downhill, stay in left lane as you enter the traffic circle. Proceed around to the left, merge to the right and take the 2nd exit (right) onto W Bay Drive NW. The office will be one block down on the right.
Date: ______________  

**Patient Information**

Last Name: ___________________________  First Name: ___________________________  Middle Initial ________

Marital Status: Single / Married / Divorced / Widowed  
Sex: _______  Date of Birth: ___________________________

Mailing Address: __________________________________ City: __________________ State: _____ Zip: _______

Physical Address: __________________________________ City: __________________ State: _____ Zip: _______

Primary Phone#: ________________________  Secondary Phone#: ________________________  Email: ________________________

Emergency Contact: ________________________  Relation: ________________________  Phone #: ________________________

Employer: ___________________________  Work Phone #: ___________________________  SS#: __________________________

**Spouse/Guarantor/Self (Please Circle)**

Last Name: ___________________________  First Name: ___________________________  Middle Initial ________

Sex: _______  Date of Birth: ___________________________

Mailing Address: __________________________________ City: __________________ State: _____ Zip: _______

Contact Phone #: ________________________  Email: ________________________

Employer: ___________________________  Work Phone#: ___________________________  SS#: __________________________

**Insurance Information**

*(PLEASE PRESENT INSURANCE CARDS AND NECESSARY REFERRALS TO THE RECEPTIONIST SO COPIES MAY BE MADE)*

**Primary Insurance:**  __________________________________  Insurance Phone #: ___________________________

Ins Address: ___________________________  Policy#: ___________________________  Group#: ___________________________

Subscriber: ___________________________  Subscriber’s Birthday: ___________________________

Relation to Patient: Same / Spouse / Child / Other (Please Circle)  Subscriber’s Employer: ___________________________

**Secondary Insurance:**  __________________________________  Insurance Phone #: ___________________________

Ins Address: ___________________________  Policy#: ___________________________  Group#: ___________________________

Subscriber: ___________________________  Subscriber’s Birthday: ___________________________

Relation to Patient: Same / Spouse / Child / Other (Please Circle)  Subscriber’s Employer: ___________________________
Welcome to our practice!
Please take the time to fill out the Health History Questionnaire below prior to your visit, as this will help speed the initial aspects of your visit with us.

Patient Name:_________________________________  DOB:_____________  Primary MD:_________________
Pharmacy:___________________

Past Medical History:
- Anxiety
- Arthritis: Type________
- Asthma
- Atrial Fibrillation / Irregular heartbeat
- BPH (prostate)
- Bone Marrow Transplant
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- Fibromyalgia
- Gastroesophageal Reflux
- Other_________________

(Please add dates)

Past Surgeries:  (Please add dates)
- Appendix (appendectomy)
- Bladder (Cystectomy)
- Breast: Mastectomy  R  L  B
- Breast: Lumpectomy  R  L  B
- Breast: Biopsy  R  L  B
- C Section
- Colon (colectomy for cancer)
- Colon (colectomy for diverticulitis)
- Gallbladder (cholecystectomy)
- Heart: PTCA
- Heart: Mechanical Valve replacement
- Heart: Biological Valve replacement
- Heart: Transplant
- Uterus: Hysterectomy_______
- Joint replacement: Knee  R  L  B
- Other:_________________

(Please add dates)

Please circle all that apply.

Past Dermatology History:
- Acne
- Actinic Keratoses (pre-cancers)
- Asthma
- Basal cell skin cancer**
- Blistering sunburns
- Dry skin
- Eczema
- Other:______________

- Flaking or itchy scalp
- Hay Fever / Allergies
- Melanoma**
- Poison Ivy
- Precancerous or atypical moles
- Psoriasis
- Rosacea
- Squamous cell skin cancer**

** If yes, please list cancer, location, date, and treatment

Staff Initials / Date________________________

Please fill out other side  →
Patient Name: _________________________________  DOB:_____________

Do you wear Sunscreen? No____  Yes_____ (SPF______)  
Tanning salon? No____  Yes_____  Past_____ 
Family history of skin cancer? No_____  Yes_____  Type:  BASAL CELL  SQUAMOUS CELL  MELANOMA  UNKNOWN  (circle one)  
If yes, (circle)  mother  father  sister  brother  daughter  son  uncle  aunt  nephew  grandmother  grandfather  grandson  granddaughter  Other_______ 

Please list any medications and supplements or vitamins that you are taking:  
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.  

Are you allergic to latex? Yes No Reaction:________________________ 

Please list any allergies to medicines or anesthesia that you may have and the reaction: 
1. 2. 3. 4. 5. 6.  

Social History:  
Do you use illicit, intravenous or recreational drugs? Yes_____Type:__________________ No__________ 
Do you drink alcohol?  No Yes (circle one) Less than 1 drink/day; 1-2 drinks/day; 3 or more drinks/day 
Do you feel safe at home? Yes______ No______ 
Marital status? Single____  Married____  Divorced____  Widowed____  Partner____  
Occupation (s):______________________________________________________________ 
Hobbies / Leisure activities:___________________________________________________ 

Where did you grow up and/or spend significant time in your life?______________________________________ 

Do you or have you ever smoked?  Current everyday smoker: _______ packs per day  
______Occasional smoker  
______Former smoker______ year quit  
______Never smoker  

How often do you exercise?  
______Several times a day  
______Once a day  
______A few times a week or month  
______Never  

What is your caffeine use?  
______Several times a day  
______Once a day  
______A few times a week or month  
______Never  

(Women) Are you pregnant? ___Yes ___No ___Are you planning?  If yes, due date?_____________ 

Page 2  
Staff Initials/Date________________
Notice of Privacy Practices Acknowledgement

Due to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we must have your written acknowledgement of having had an opportunity to receive and review a copy of our Notice of Privacy Practices.

I, ________________________________________ acknowledge the opportunity to review and receive Dermatology and Allergy Specialists of Olympia, PLLC. Notice of Privacy Practices.

OFFICE USE ONLY:

☐ Patient refuses, or is unable to acknowledge receipt of the Notice of Privacy Practices.

________________________________________  ______________________
Employee Signature                        Date

Disclosures to Family and Friends and Clinical Information Calls

Under normal circumstances we would share some of your private health information (PHI) with some of your family members. Please read and complete both of the following:

1. I agree that this office may disclose my private health information to only the following individuals that are my family members or friends (PLEASE PRINT)

NAME: ______________________________ PHONE NUMBER: __________________
RELATIONSHIP: __________________    ☐ ALL INFORMATION    ☐ FOR EMERGENCY ONLY

NAME: ______________________________ PHONE NUMBER: __________________
RELATIONSHIP: __________________    ☐ ALL INFORMATION    ☐ FOR EMERGENCY ONLY

OR:

☐ I do not want my private health information disclosed to any individual asking about me, regardless of whether or not they may be a family member or friend.

2. How would you like us to communicate with you regarding clinical information (such as test results and treatment plans)? Following your visit may we call and leave a message on the following:

☐ Home Phone (____) __________________   ☐ Cell phone (____) __________________
☐ Work Phone (____) __________________  ☐ Other (____) __________________

__________________________________________________________  ______________________
Signature                        Date

Relationship to patient if signed on behalf of the patient

J. Mark Bauer, MD    Jacob H. Bauer, MD    Linda L. Brown, MD    Michael K. Elm, MD    Sukanya Kanthawatana, MD, PhD    Shauna M. Richert, MD
Samantha Ferguson, PA-C    Sarra Vashchenko, PA-C    Jennifer Winter, PA-C