Dermatology Clinic of Spokane

William A. Wray, MD and Irene Bayer, PA-C

309 E. Farwell Rd – Suite 206
Spokane, WA 99218
Ph: 509.484.4591 Fax: 509.484.7882

Patient Information

(Please print clearly)

Patient Name _____ Phone _____
Patient Address _____
City _____ State _____ Zip _____
Occupation _____ Employer_____

Patient Date of Birth _____Sex at birth: Male [ ] Female [ ] Widow [ ] Married [ ] Single [ ]
Social Security #_____-_____-_____ (For Insurance billing & treatment auths)
Language _____
Ethnicity – Hispanic / Non-Hispanic or Latino Race _____
Email address _____

(Email address is used to access your patient portal)

If patient is a minor, name of parent or guardian _____ Phone _____
Address (if different from patient) _____
Social Security #_____ Date of Birth_____

Primary Insurance Information	**Secondary Insurance Information**
Insurance Co_____	Insurance Co _____
ID # _____	ID # _____
Group # _____	Group # _____

Do you have a Power of Attorney? Yes [ ] No [ ]
POA Name _____ Phone _____

Is it okay to call your preferred number and confirm your medical appointments? Yes [ ] No [ ]
Is it ok to leave a detailed message on your voicemail regarding health information, including results Yes [ ] No [ ]

For every day information, prescriptions, test results, and appointment reminders, is there someone we may speak to besides you? Yes [ ] No [ ]

Name _____Phone _____ Relationship to You _____
Name _____Phone _____ Relationship to You _____

We will only release your protected health information to the people you wish us to. We will not release written records without your written permission

Signature _____

Print Name _____Date _____
Patient, Parent, Guardian, or Personal Representative

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Medical History

Patient Name _____ Date of Birth _____
Primary Care Doctor Name _____ Phone _____
Pharmacy Name & Address: _____
List all known Drug Allergies or Reactions: _____

Do we have permission to access your pharmacy information through our medical record system? Yes [ ] No [ ]

Names of Prescriptions, Vitamins, & Supplements (Blood thinners/ Fish Oil / Vit E, etc.)

_____ _____
_____ _____
_____ _____
_____ _____

Band-aid Allergy? Yes [ ] No [ ] Polysporin/Neosporin ? Yes [ ] No [ ]
Do you take Aspirin Daily? Yes [ ] No [ ]

Past Medical History (mark all that apply):

____ Anxiety	____ Coronary Artery Disease	____ Leukemia
____ Arthritis	____ Depression	____ Lung Cancer
____ Asthma	____ Diabetes	____ Lymphoma
____ Atrial Fibrillation	____ End Stage Renal Failure	____ Melanoma
____ Bone Marrow Transplantation	____ GERD	____ Prostate Cancer
____ Basal Cell Cancer	____ Hearing Loss	____ Radiation
____ Bleeding Disorders	____ Hepatitis	____ Seizures
____ BPH (Enlarged Prostate)	____ Hypertension	____ Squamous Cell CA
____ Breast Cancer	____ Hypercholesterolemia	____ Tuberculosis
____ Colon Cancer	____ Hyperthyroidism	____ Venereal Disease
____ COPD	____ Hypothyroidism	____ Other_____

Past Surgical History (mark all that apply):

____ Appendix (Appendectomy) _____
____ Bladder (Cystectomy)_____
____ Breast (Lumpectomy, Mastectomy) _____
____ Colon (Colon Resection, Colon Cancer, Diverticulitis, Colostomy) _____
____ Gallbladder (Cholecystectomy) _____
____ Heart (Pacemaker, Stent, Transplant) _____
____ Joint Replacement (Hip, Knee, Shoulder) _____
____ Kidney (Kidney Biopsy, Kidney Stone, Kidney Transplant) _____
____ Liver (Hepatectomy, Liver Transplant, Shunt) _____
____ Ovaries (Oophorectomy – Ovarian Cancer, Endometriosis) _____
____ Pancreas (Pancreatectomy) _____
____ Prostate (Biopsy, Prostatectomy, TURP) _____

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Surgical History, cont.

____Rectum (APR, Low Anterior Resection) _____
____ Skin (Skin Biopsy, Squamous Cell Carcinoma, Melanoma) _____
____ Spleen (Splenectomy) _____
____ Testicles (Orchiectomy) _____
____ Tonsils (Tonsillectomy) _____
____ Uterus (Hysterectomy – Fibroids, Uterine Cancer, Cervical Cancer) _____

Skin Disease History (mark all that apply):

____ Acne
____ Actinic Keratosis
____ Basal Cell Carcinoma
____ Blistering Sunburns
____ Dry Skin
____ Eczema
____ Flaking or Itching Scalp
____ Herpes (Cold Sores/Genital)
____ Melanoma - Location: _____
____ Poison Ivy
____ Precancerous Mole: Mild/Moderate/Severe (Location)
____ Psoriasis
____ Squamous Cell Carcinoma
____ Staph
____ Warts
____ Other

Do you wear sunscreen? YES / NO Do you tan in a tanning salon? YES / NO

Family History:

Do you have a family history of Melanoma? YES / NO If yes, which relative? _____
Do you have a family history of Precancerous Moles, Basal Cell Carcinomas, or Squamous Cell Carcinomas? YES / NO If yes, which relative? _____

Social History (mark all that apply) :

Smoking/ Tobacco Use: ____ Current Every day smoker ____ Current Some Days smoker
____ Current Tobacco (Chew) User ____ Former Smoker ____ Never a smoker

Family Planning:

Are you currently pregnant or trying to get pregnant? Yes [ ] No [ ]

Vaccination Status/Advance Care Planning:

Have you received a pneumonia injection? YES/ NO Date: _____

Do you have a health care proxy in the event you are unable to make your own medical decisions? YES / NO