Dermatology Associates of Virginia, P.C.
PLEASE PRINT

Date: _____ Account #:_____

SECTION 1: PATIENT INFORMATION

Patient's Name: _____
First Name M.I. Last Name

Nickname/Preferred Name: _____

Address: _____
Street Apt/Suite/Unit City/State Zip Code

*****Please Check Preferred Daytime Contact Phone Number*****

☐ Home Phone: (_____) _____ ☐ Work Phone: (_____) _____

☐ Cell Phone: (_____) _____ Email: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

SECTION 2: PRIMARY CARE/REFERRING PHYSICIAN INFORMATION

Primary Care Physician: _____

Referring Physician if Different than Primary Care Physician: _____

SECTION 3: PARENT OR LEGAL GUARDIAN INFORMATION – FOR MINORS ONLY

LEGAL GUARDIAN or PARENT NAME: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ **Date of Birth:** _____

SECTION 4: INSURANCE INFORMATION

PRIMARY Insurance Carrier: _____

Name of Policy Holder: _____Policy Holder's Date of Birth: _____ M F

Policy Holder's ID #: _____Patient's Relationship to Policy Holder: □Self □Spouse □Child □Other

SECONDARY Insurance Carrier: _____

Name of Policy Holder: _____Policy Holder's Date of Birth: _____ M F

Policy Holder's ID#: _____Patient's Relationship to Policy Holder: □Self □Spouse □Child □Other

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM

SECTION 5:

1) **Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ More than One Race ☐ Refused to Report

2) **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report

3) **Preferred Language:** _____

4) **Preferred Notification Method:** ☐ Postal Mail ☐ Phone ☐ Patient Portal Message

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SECTION 6: PATIENT EMPLOYMENT INFORMATION

Patient's Employer: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Self Employed ☐ Student

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SECTION 7: EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: (_____) _____

SECTION 8: DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

☐ **Same as Emergency Contact.**

Name: _____Relationship: _____Phone #: (___) _____

Name: _____Relationship: _____Phone #: (___) _____

Name: _____Relationship: _____Phone #: (___) _____

☐ I DO **NOT** GIVE PERMISSION TO DISCLOSE PERSONAL MEDICAL INFORMATION ABOUT MY TREATMENT TO FAMILY MEMBERS OR FRIENDS.

SECTION 9:

May we leave personal medical information on your answering machine? ☐ YES ☐ NO

JOIN OUR PATIENT PORTAL? ☐ YES ☐ NO

SECTION 10: PHARMACY INFORMATION

Local Pharmacy Name: _____ Phone #: (___) _____

Address: _____

Mail Order Pharmacy Name: _____ Phone #: (___) _____

Address: _____

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM

DAV
Dermatology Associates of Virginia, P.C.

Date: _____ **Chart #:** _____

Medical History Form

Name: _____ **Date of Birth:** _____

LOCAL Pharmacy: _____ **MAIL ORDER** Pharmacy: _____

Phone #: (_____) _____ Phone #: (_____) _____

Address: _____ Address: _____

ALLERGIES: Including medications, local anesthetics, or latex. Please circle YES or NO.
If YES, please list name and **reaction**.

YES NO _____

_____

MEDICATIONS: Are you taking any prescription drugs, over-the-counter medications, vitamins, or herbs?
If YES, please list. Include name, **dose, and how often** - continue on back, as needed.

YES NO _____ _____ _____

_____ _____ _____

_____ _____ _____

Risk Factors: Do you have or have you had any of the following? If yes, please explain below (with date).

YES	NO	Melanoma	YES	NO	Frequent sun exposure or blistering sunburns
YES	NO	Basal or squamous cell skin cancer	YES	NO	Tanning bed use (If YES, how often?)
YES	NO	Family history of melanoma	YES	NO	Radiation therapy
YES	NO	Family history of other skin cancer	YES	NO	Arsenic exposure

_____

Medical History: Do you have any medical conditions? If you circle YES, please explain below (with date).

YES	NO	Artificial Heart Valve	YES	NO	Heart Disease
YES	NO	Pacemaker/Defibrillator	YES	NO	High Blood Pressure
YES	NO	Joint Replacement	YES	NO	Diabetes
YES	NO	Women: Pregnant or Nursing	YES	NO	Kidney Disease
YES	NO	Women: Trying to get Pregnant	YES	NO	Liver Disease
YES	NO	HIV/AIDS	YES	NO	Lung Disease
YES	NO	Hepatitis B or C	YES	NO	Tuberculosis
YES	NO	History of Blood Transfusions	YES	NO	Glaucoma
YES	NO	Transplanted Organ	YES	NO	Seizure Disorder
YES	NO	Bleed Easily	YES	NO	Skin Condition (other than skin cancer)
YES	NO	Stroke/TIA	YES	NO	Other Medical Problems

_____

Surgical History: Have you ever had surgery? If YES, please list type of surgery and date.

YES NO

Social History:

What is your occupation? _____

YES NO Do you smoke? (If YES, how much and how long?) _____

YES NO If you answered NO above, did you ever smoke? (If YES, when did you quit?) _____

YES NO Do you drink alcohol? (If YES, how much?) _____

Patient's Signature (or legal guardian) _____ **Date** _____

Physician's Signature _____ **Date** _____

Dermatology Associates of Virginia, P.C.

Patient Name: _____ Account #: _____

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

- **Consent for treatment**
  I authorize Dermatology Associates of Virginia to render treatment to me/my dependents for dermatological care, including all necessary laboratory and pathologic services.

- **Assignment of Benefits/Release of medical information**
  I request that payment for authorized Medicare or other applicable private insurance benefits be paid directly to Dermatology Associates of Virginia for services provided under their care. I also authorize Dermatology Associates of Virginia to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

- **Digital Photography**
  I authorize the physicians/staff of Dermatology Associates of Virginia to take digital photographs that relate to my care. Dermatology Associates of Virginia will only disclose information relevant to current treatment.

- **Electronic Recording**
  I understand that, in order to maintain the privacy of the patients and staff of Dermatology Associates of Virginia, I am not allowed to audio record, videotape, or photograph on the premises without the express consent of my physician.

- **Financial Responsibility**
  I understand that I am ultimately responsible for any unpaid balance or non-covered service.

- **Referrals/Authorizations**
  I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

- **Missed Appointments**
  Our office requires 24 hour notice for cancellations. Failure to do so may result in a $20.00 fee.

- **HIPAA Disclosure form**
  I acknowledge that I have reviewed a copy of Dermatology Associates of Virginia's Notice of Privacy Practice which includes electronic access to medication history. I understand that Dermatology Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact Dermatology Associates at any time to obtain a current copy of the Notice of Privacy Practices.

I have reviewed the statements above and understand my responsibilities.

_____ _____

Patient Signature (Or Parent/Legal guardian of minor) **Date**

_____

Print Name