New Patient Information Form

DERMATOLOGY SPECIALISTS OF VIRGINIA

NEW PATIENT/PATIENT UPDATE INFORMATION SHEET

NAME: _____ Date of Birth _____ email: _____

Age: _____ Sex: M F Martial Status: S M W D Sep SSN: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip _____

Phone: Home: _____ Cell: _____ Work: _____

Employer: _____ Relationship to Subscriber: _____

Please answer the questions below by Government mandate:

Race: Caucasian American Indian or Alaska Native Asian African American Native Hawaiian or other Pacific Islander Other Refuse to answer

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Refuse to specify

Preferred Language _____

Referred by: _____ Family Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

PLEASE PROVIDE YOUR INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST AT EACH VISIT.

INSURANCE COVERAGE:

Insurance company: _____ Pol# _____ Grp# _____

Subscriber: _____ DOB: _____ Phone# _____

You have the right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, and any other person identified by you.

With whom may we share your medical information? _____

May we leave medical information on your answering machine? Circle one: YES NO

Pharmacy Name:	**Address and phone number**:

We will bill your insurance company if we participate with that company. You are responsible for any & all charges that your insurance company does not cover such as deductibles, co-pays, and non-covered services, which are payable at the time of service. Parents are responsible for payments on child accounts. All tissue removed will be sent for pathologic examination. There is a $35 fee for returned checks. I authorize for insurance payments to go directly to physician and for release of necessary medical records to the insurance company and to the billing service to receive payment. HMO Participants: In order for your insurance to pay for your visit, it is your responsibility to obtain referrals from your primary care physician for each visit. I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. My requested restrictions of use of this information are notated above. I certify that I understand the above and that the information I have given is correct to the best of my knowledge:

_____ _____

Signature (parent/guardian if minor) Date

NAME:_____

PAST MEDICAL HISTORY *— Please circle any you have or had:*

Anxiety	Coronary Artery Disease	Hypercholesterolemia	Seizures
Arthritis	Depression	Stomach ulcers/digestive	Stroke
Asthma	Diabetes	Hyperthyroidism	
Atrial Fib	End stage renal disease	Hypothyroidism	Other problems–
BPH	GERD	Leukemia	*list: _____
Bone marrow transplant	Hearing loss	Lung cancer	_____
Breast cancer	Hepatitis	Lymphoma	_____
Colon cancer	Hypertension	Prostate cancer	_____
COPD	HIV/AIDS	Radiation treatment	_____

LIST ANY SURGERIES: _____

SKIN HISTORY — *Please circle any you have or had*

Acne	Dry skin	Melanoma	Squamous cell skin cancer		
Actinic Keratoses	Eczema	Poison ivy	Do you wear sunscreen?	Yes	No
Asthma	Flaking/itchy scalp	Precancerous moles	Is there family history of melanoma?	Yes	No
Basal Cell skin cancer	Hay fever/allergies	Psoriasis	If yes, which relative? _____		

CURRENT MEDICATIONS:

ALLERGIES: Are you allergic to any medications? if so, please list below

Medication	What happens? (eg. hives, trouble breating, etc)

SMOKING HISTORY (CIRCLE ONE): everyday smoker some day smoker former smoker never smoker

CIRCLE any you have below: (ROS)

Problems with bleeding	Thyroid problems	Shortness of breath	Defibrillator
Problems with healing	Sore throat	Wheezing	MRSA
Problems with scarring	Blurry vision	Anxiety	Pacemaker
Rash	Abdominal pain	Depression	Rapid heart beat with epinephrine
Immunosuppression	Joint aches	Allergy to adhesive	
Hay fever	Muscle weakness	Allergy to lidocaine	**Are you Pregnant or Planning a Pregnancy?**
Chest pain	Neck stiffness	Allergy to topical antibiotic	**Yes ☐ No ☐**
Fever of chills	Headaches	Artificial heart valve	**Are you Nursing?**
Night sweats	Seizures	Artificial joints	**Yes ☐ No ☐**
Unintentional weight loss	Cough	Blood thinners	