DERMATOLOGY INC. OF VIRGINIA BEACH

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Phone: 757-481-4422 Fax: 757-481-9182

Date:_____ Chart:_____

Patient Name:_____
(PLEASE PUT NAME AS IT APPEARS ON YOUR INSURANCE CARD)

Address:_____
(Street) (Apt.) (City) (State) (Zip)

Age:_____ Date of Birth:_____ Marital Status: M W D S

Home Phone:_____ Work/Cell #:_____ Social Security #:_____

Gender: M / F E-Mail Address:_____

Emergency Contact Name:_____ Phone:_____

Everyone Please Fill Out The Next Section:
If Patient is a Child, Information Pertains to the Parents – If Patient is an Adult, Information Pertains to You.

Person responsible for payment:_____

Address if Different than Above:_____

Occupation:_____ Employer:_____

Employer's Address:_____

Work Phone_____ Date of Birth:_____ SS#:_____
(If Different From Above)

Name of Spouse:_____ Occupation:_____

Spouse's Employer and Address:_____

Spouse Social Security #:_____ Spouse Date of Birth:_____

Primary Insurance Company_____ *****PLEASE PRESENT ALL INSURANCE CARDS**

Subscriber's Name:_____ ID#_____

Secondary Insurance Company_____ ****ARE YOU ELIGIBLE FOR TRICARE FOR LIFE Y OR N . IF YES, HAVE YOU ACCEPTED THIS AS YOUR SECONDARDY INSURANCE PLAN.**

Subscriber's Name_____ ID#_____

I authorize you to release my medical information (i.e.: Biopsy results), to the following:

_____ _____

_____ _____

May we leave information on your cell phone? Y / N

PLEASE COMPLETE BACK OF FORM

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DERMATOLOGY INC. OF VIRGINIA BEACH

Name:_____

Reason for Visit:_____Duration:_____
(Please be Specific)

Patient Referred By:_____Family Physician:_____

PLEASE CHECK ...THE PROBLEMS THAT APPLY TO YOU:

Do you have to be premedicated prior to dental procedures?_____
Do you have a pacemaker or a defibrillator?____
Do you have any artificial joint replacement?____

FEMALES: Are you pregnant?_____

PERSONAL HISTORY:
Occupation:_____
_____Smoke Amount_____
_____Blood Transfusion Year_____
_____Tested for AIDS Year and Result_____

MEDICATIONS NOW TAKING (Include over the Counter medications and aspirin)
Type: Dose:
_____
_____
_____
_____
_____
_____

I have ALLERGIES to the following MEDICATIONS:
_____
_____
_____
_____
_____
_____

Have you been diagnosed with:
_____Malignant Melanoma
_____Other Skin Cancer

PAST HISTORY:

_____MEDICAL PROBLEMS:
_____Diabetes
_____Cancer Types:_____
_____Anemia
_____Arthritis
_____Stomach/Bowel Problems Types:_____
_____High Blood Pressure
_____Heart Trouble
_____Thyroid Problems
_____Urinary Problems Types:_____
_____Hepatitis
_____Liver Problems
_____Neurologic Disorders Types:_____
_____Asthma/Lung Disorder
_____Lupus or other collagen vascular disease
_____High Cholesterol
_____Psychological Disorders
_____Kidney Disease

PREVIOUS SURGERY (List all surgery)
Type: Date:
_____
_____
_____

Has anyone in your family been diagnosed with:
_____Malignant Melanoma
_____Other Skin Cancer

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE... I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the physician or supplier for services rendered.

AGREEMENT TO BE FINACIALLY RESPONSIBLE:

I/We, _____ (guarantor) agree to be financially responsible for the cost of all medical services rendered to the patient by Dermatology Inc. of Virginia Beach. If payment for these services is not made when requested, I agree to pay, in addition to the physician's fee, all costs of collecting the amount due. If this account is turned over to an attorney for collection, the undersigned agrees to pay interest on the unpaid balance at the rate of 1.5% per month (18% per annum) from the date that said monies became due and attorney's fee of thirty-three and one-third percent (33.3%) of the principal amount due and owing when turned over to said attorney for collection. I understand that my insurance will be filed for me as a courtesy and that I will be responsible for payment of any amount not paid by the insurance company because of all applicable deductibles, including surgery deductibles, co-insurance, lapse of coverage or cancellation of coverage. If you have insurance coverage with a company with whom we do not participate, you will be asked to pay for the cost of the office visit on the day of service. We will file your insurance claim for you so that you can receive your reimbursement.

_____ _____
(Signature) (Date)

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NOTICE OF CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorized health care providers to test their patients for HIV antibodies when the health care provider is ACCIDENTALLY EXPOSED to blood or body fluids in a manner which may transmit the human immunodeficiency virus (HIV). However, you would be informed before any of your blood would be tested for HIV antibodies. The testing would be explained and you would be given the opportunity to ask any questions you might have.

In addition, the event one of our health care providers is exposed to potentially infectious body fluids, permission in herby granted to test my blood for Hepatitis B and C.

THE EXPENSE IS COVERED BY DERMATOLOGY INC. OF VIRGINIA BEACH. YOU WOULD BE INFORMED PRIOR TO ANY BLOOD TESTING BY THE DOCTOR FOR THE HIV HEPATITIS B AND C ANTIBODIES.

Patient's Name

Date

DERMATOLOGY INC. OF VIRGINIA BEACH

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dermatology Inc. Of Virginia Beach (Dermatology Inc.) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent and I have been provided with a copy for my personal records. Dermatology Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology's Privacy Officer at 1200 First Colonial Road, Suite 200, Virginia Beach, VA 23454.

With my consent, Dermatology Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology Inc. may mail to my house or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right request that Dermatology Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology Inc. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian