DERMATOLOGY SPECIALISTS OF VIRGINIA

☐ NEW PATIENT ☐ PATIENT UPDATE

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

Name: _____ Email: _____

Age: _____ DOB: _____ Sex: **M F** Marital Status: **S M W D Sep** SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____

Cell #: _____ Would you like to recieve text message reminders? ☐ yes ☐ no

Preferred Language:_____ Employer: _____ Insurance Policy Holder:_____

Primary Care Provider: _____ Practice Name/Phone: _____

☐ I do not have a primary care provider

☐ I do not wish to disclose my primary care provider information

Emergency Contact: _____ Relationship: _____ 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.

**May we share your medical information with your emergency contact? Yes No**

**Do you have a power of attorney? Yes No If yes, who? _____**

**All prescriptions will be sent electronically to your pharmacy.**

Pharmacy name: _____ Phone #: _____

Address: _____

Please circle preferred laboratory for blood work: **Quest** **LabCorp**

We will bill your insurance company if we participate with them. You are responsible for any and all changes 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. Appointments canceled without 24 hours notice will be charged a $25 fee. I authorize for insurance payments to go directly to the physician, for the billing service to receive my payment, and for release of necessary medical records to the insurance company.
HMO Participants: A referral is required 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. If your visit is denied for lack of referral, you will be responsible for the full amount.

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

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**PAST MEDICAL HISTORY** - *please circle any you have or had:*

Anxiety
Asthma
Atrial Fib.
Benign prostate hyperplasia
Bone marrow transplant
Breast cancer
Colon cancer
Radiation treatment

COPD
Coronary artery disease
Depression
Diabetes
End stage renal disease
Hearing loss
Hepatitis
High blood pressure

High cholesterol
HIV/AIDS
Hyperthyroidism
Hypothyroidism
Leukemia
Lung cancer
Lymphoma
Prostate cancer

Seizures
Stroke
Transplanted organ
if yes, which?_____

*Other problems (please list): _____

_____

**LIST ANY SURGERIES**: _____

_____

**SKIN HISTORY** - *please circle any you have or had:*

Acne
Actinic keratoses
Asthma
Basal cell skin cancer
Blistering sunburns

Dry skin
Eczema
Flaking/itchy scalp
Hay fever/allergies
Melanoma

Merkel cell carcinoma
Precancerous moles
Psoriasis
Squamous cell skin cancer
Tanning bed exposure

**Is there a family history of melanoma?**
**Yes** **No** Which relative?_____

**Non-melanoma family history?**
**Yes** **No** Which relative?_____

| **CURRENT MEDICATIONS:** | **DOSAGE/FREQUENCY:** | **REASON:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**DRUG ALLERGIES:** _____

**SMOKING HISTORY :** ☐ everyday smoker ☐ some days smoker ☐ former smoker ☐ never smoked

**CIRCLE ANY YOU HAVE CURRENTLY:**

Problems with scarring
Rash
Immunosuppression
Chest pain
Fever or chills
Unintentional weight loss
Shortness of breath

Thyroid problems
Sore throat
Joint aches
Muscle Weakness
Neck stiffness
Headaches
Seizures

Wheezing
Allergy to adhesive
Allergy to lidocaine
Allergy to Iodine
Artificial heart valve
Artificial joints (past two years)
Blood thinners

MRSA
Pacemaker
Rapid heartbeat
with epinephrine

**PATIENTS 65+ only** - *please circle*
**Have you ever had a pneumonia vaccine?** **Yes** **No**
**Do you have a healthcare proxy in the event you are unable to make healthcare decisions for yourself?** **Yes** **No** **If yes, who?** _____
**Do you have a living will?** **Yes** **No**

**FEMALE Patients only** - *please circle:*
**Are you pregnant?** **Yes** **No**
**Are you planning a pregnancy?** **Yes** **No**
**Are you nursing?** **Yes** **No**

**Number of pregnancies:** _____
**Number of live births:** _____