Please complete all forms and present with your insurance card and photo ID to the front desk

PATIENT INFORMATION

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Patient Name _____
Last First M.I.

Date of Birth: ____/____/____ Age: _____ Sex: ____

Mailing Address _____
City State Zip

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

Cell Phone: ( )_____ e-mail: _____

PRIMARY INSURANCE COVERAGE

Insurance Co. Name:_____

Address of Claim Center:_____

_____
City State Zip

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other_____

SECONDARY INSURANCE COVERAGE

Insurance Co. Name:_____

Address of Claim Center:_____

_____
City State Zip

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other_____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____Date of Birth: ____/____/____
Last First M.I.

Address:_____
City State Zip

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

Cell Phone: ( )_____ e-mail: _____

REFERRAL

Patient Name(Print)_____
Today's Date ____/____/___

Primary Care Physician _____
PCP Phone ( )_____

Referring physician (if different from PCP). _____
Phone ( )_____

Preferred pharmacy name_____ Pharmacy phone #_____

EMERGENCY CONTACT INFORMATION

In case of Emergency, who should be notified?_____
Phone ( )_____
Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?
( ) YES ( ) NO If yes, please provide their names and phone numbers below.
Name: _____
Relationship: _____
Phone # (day): (_____)_____
Phone # (evening): (_____)_____
May we leave personal medical information on your answering machine or cell phone? ( ) YES ( ) NO
May we e-mail personal medical information to you? ( ) YES ( ) NO

E-mail address: _____

PAYMENT POLICY/AGREEMENT

You are responsible for paying at the time of service for your co-payment, annual deductible, and charges for any non-covered cosmetic services. The entire unpaid balance remaining after your insurance has paid its portion is your responsibility and will be billed to you, regardless of the benefits and payment policies of your carrier.

Patients who are covered by plans in which our physicians do not participate (Out of Network) are required to pay the total bill at the time of the service.

Patient or Responsible Party Signature _____

Patient or Responsible Party Name (Print)_____

Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC **OKKC**
BOARD CERTIFIED IN DERMATOLOGY

243 Church Street, NW, Suite 200-C
Vienna, VA 22180
Tel. 703-938-5700 Fax 703-938-4467

Date_____ **Name**_____**Date of Birth**_____
LAST, FIRST, MI

REVIEWED BY STAFF_____

Past/family/social/history

Personal History Eczema Asthma Hay fever/allergic rhinitis Psoriasis Multiple Sclerosis

Family History Eczema Asthma Hay fever/allergic rhinitis Psoriasis Multiple Sclerosis

Occcupation_____ **Hobbies**_____

Use of sun screen_____ SPF_____ **Smoker - Yes**_____**No**____

History of Skin Cancer Melanoma Basal cell Squamous cell

History of other Cancer_____metastasis_____

Family History of Skin Cancer Melanoma Non-Melanoma skin cancer

History of Hepatitis? History of Blood Transfusion HIV/exposure

Reaction/contact dermatitis: Tape/Bandage Topical Antibiotic Other

Surgeries:

ROS

PLEASE ANSWER **YES** OR **NO** to the Following - If **YES** - Circle and give details

YES NO

_____ **Trouble Healing** Thick Scar/Keloid

_____**Immunosuppression** Cause Organ Transplant

_____**Vision Problem** Cataracts Glaucoma Glasses Other vision problems

_____**Hearing, Smelling, Swallowing, Dental/Mouth problems** Hearing loss

_____**Difficulty Breathing** Asthma Emphysema Other

_____**Urinary difficulty** (Men) Prostate Incontinence

_____**Abdominal pain/Ulcer** Blood in stool Diarrhea Other

_____**Joint Pain** Artificial Joints Knee ☐ Hip ☐ Muscle Weakness Other

_____**Enlarged Lymph Nodes** Excessive Bleeding Abnormal white blood cells

_____**Irregular heart beat** Chest Pain Pacemaker /Defibrillator Enlarged heart

High Blood Pressure Murmur Mitral Valve Prolapse Blood Clots

_____**Numbness/Loss of Sensation** Loss of movement control Headache

_____**Abnormal Moods** Depression Anxiety Learning Disability Other

_____**High Blood Sugar** Enlarged Thyroid /Goiter Excessive hair growth Weight gain

_____**Women** Abnormal Cycle/Irreg. Menses _____ Infertillity _____ Heavy Bleeding _____ Post Menopausal _____

_____ Pregnant? _____ Trying to conceive?_____ Breast Feeding?_____ Using contraception? _____

Breast Lumps _____ Breast Cancer _____

_____**Current Medication(s)** Oral_____ or Iv_____, mg_____, Frequency_____

Names of meds_____

Latex (Rubber) Allergies?

_____**Allergy to Anesthetic?**

_____**History of reaction to local anesthesia?**

_____**Medication Allergy/Reaction**

_____**Vaccination for pneumonia**

_____**Vaccination for flu**

Are you taking Aspirin___Coumadin___Ibuprofen___or Naproxen_____

Do you faint easily?_____Antibiotic before dental procedures?_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am a patient of D&DSG. I hereby acknowledge receipt of D&DSG 's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].

I hereby acknowledge receipt of D&DSG 's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____