PATIENT INFORMATION FORM

Dermatology CENTER of Winchester

Please PRINT.

First name: _____ Last name: _____ M.I. _____
SSN#: _____-_____-_____ Sex: M / F Birth Date: _____ / _____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #s Cell: _____ Work: _____ Home: _____
Job Title: _____ Employer: _____
Race: _____ Ethnicity (Please check one) □ Hispanic or Latino □ Not Hispanic or Latino
Preferred Language (Please check one) □ English □ Spanish
Status: married, single, widowed, divorced

INSURANCE SUBSCRIBER - The person who holds the insurance plan – often through employer.
Skip this section if the patient is the insurance policyholder.
Relationship to patient (ex: self, spouse, father, mother): _____
First name: _____ Last name: _____ M.I. _____
SSN#: _____-_____-_____ Sex: M / F Birth Date: _____ / _____ / _____
Phone #s Home: _____ Work: _____ Cell: _____
Job Title: _____ Employer: _____

(Please bring all insurance cards with you to every office visit. Thank you.)

PRIMARY INSURANCE
Insurance company: _____
Insurance ID#: _____ Insurance Address: _____
Group# (if applicable): _____

SECONDARY INSURANCE (if applicable)
Insurance company: _____
Insurance ID#: _____ Insurance Address: _____
Group# (if applicable): _____

I authorize my insurance benefits to be paid directly to the physician. I acknowledge that I am financially responsible for all charges, and that it is my responsibility to verify that my insurance will cover any procedures that are performed at my request. If my insurance company requires a referral, I understand that it is my responsibility to obtain such a referral prior to my visit. If Medicare or my commercial insurance carrier should deny any charges, then I agree to be personally and fully responsible for any balance due for services rendered. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Loudoun Medical Group (LMG) or any of its affiliates, agents, or lenders. If I fail to meet my financial commitment and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

I authorize LMG to test my blood for hepatitis and HIV if, in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

I give LMG permission to share my medical information with external PRISMA sites for better interoperability and patient health outcomes.

Signature: _____ Date: _____

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MEDICAL HISTORY

FULL NAME: _____ Name you would like us to use: _____
EMAIL: _____
Were you referred by a physician? Yes / No. If no, how did you find us? _____
If yes, name of referring Dr.: _____ Location: _____
Primary Care Physician: _____ Location: _____
Pharmacy Name and Address: _____**Pharmacy Phone:** _____
EMERGENCY CONTACT: _____ Phone _____ Relationship: _____

MEDICAL HISTORY
Please list all **medications** (include over the counter): _____
_____

List all previous **surgeries**: _____

Do you have any **drug allergies?** Yes / No. If yes, please list: _____

Do you have any of the following? (If yes, please explain below)

Breathing problems	Yes / No	Artificial heart valve	Yes / No
Heart problems	Yes / No	Artificial joint	Yes / No
Diabetes	Yes / No	Do you take antibiotics before dentist?	Yes / No
High blood pressure	Yes / No	Do you have a pacemaker or defibrillator?	Yes / No
Liver problems	Yes / No	Have you had problems with bleeding?	Yes / No
Hepatitis	Yes / No	Are you on a blood thinner?	Yes / No
Kidney problems	Yes / No	Have you had abnormal scarring (keloid)?	Yes / No
Stroke	Yes / No	Are you immunocompromised?	Yes / No
HIV / AIDS	Yes / No	Do you smoke? Yes / No (If yes, packs/day _____)	
Cancer	Yes / No	Do you wear : glasses / contacts / dentures / hearing aids	
Organ transplant	Yes / No	Do you drink alcohol? Never / Occasionally / Regularly	

_____

SKIN CANCER HISTORY

Have you ever had skin cancer? Yes / No If yes, what type? _____
Has anyone in your family had skin cancer? Yes / No If yes, explain. _____
Do you examine your moles for changes? Yes / No Are any of your moles changing? Yes / No
Occupation (if retired, then prior occupation): _____
Do you have a personal history of painful or blistering sunburns? Yes / No
For sun exposure purposes, where did you grow up? _____

PRIVACY POLICY
I acknowledge receiving a copy of Loudoun Medical Group's Notice of Privacy Practices. Yes / No

Signature: _____ **Date:** _____

PATIENT INFORMATION FORM

Dermatology CENTER of Winchester

Consent for Treatment

I hereby consent to medical evaluation and treatment as deemed necessary by my provider at the Dermatology Center of Winchester. This may include, but is not limited to:

- Biopsy
- Liquid nitrogen (cryotherapy)
- Curettage
- Electrodessication and Curettage (ED&C)
- Intralesional and intramuscular injections
- Incision and drainage

I understand that any procedures will be discussed with me, and I will have the opportunity to ask questions before they are performed.

Signature: _____ **Date:** _____

Phone number to call with any biopsy reports or lab results: _____

Select One

You have my permission to leave a message at the above phone number.
Do not discuss my medical care with anyone but me.
You have my permission to discuss my medical care with:_____