DERMATOLOGY INC. OF VIRGINIA BEACH
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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:
_____
_____
_____
_____
_____
_____

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:
_____
_____
_____

Have you been diagnosed with:
_____Malignant Melanoma
_____Other Skin Cancer

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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