

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 Gender: M / F

Home Phone: _____ Cell #: _____ Social Security #: _____
How would you like to be contacted ? (please circle one) HOME PHONE / CELL PHONE / E-MAIL / TEXT MESSAGE

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 SECONDARY INSURANCE PLAN.

Subscriber's Name _____

ID# _____

Pharmacy: _____ Phone #: _____

Pharmacy Location: _____

PLEASE COMPLETE BACK OF FORM

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 require antibiotics prior to dental procedures? _____

Do you have a pacemaker or a defibrillator? _____

Do you have any artificial joint replacement? _____

FEMALES: Are you pregnant? _____

Are you breastfeeding? _____

PERSONAL HISTORY:

Occupation: _____

_____ Smoke Amount _____

_____ Alcohol Amount _____

Height _____ Weight _____

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 (basal/squamous cell)

PAST HISTORY:

MEDICAL PROBLEMS:

_____ Diabetes

_____ Cancer Types: _____

_____ Anemia

_____ Arthritis

_____ Stomach/Bowel Problems Types: _____

_____ High Blood Pressure

_____ Heart Trouble

_____ Thyroid Problems

_____ Urinary Problems

_____ Infectious Disease (AIDS/HIV, 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 (basal/squamous cell)

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 physical or supplier for services rendered.

AGREEMENT TO BE FINANCIALLY 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 collected 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 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)