WEST VIRGINIA DERMATOLOGY & SKIN SURGERY CENTER

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PATIENT INFORMATION

DATE:

Name: _____ Gender: ____ DOB: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Main Phone #: _____ Home / Cell / Work Secondary #: _____ Home / Cell / Work

Email: _____

- Where may we leave **appointment reminders?** (Circle): Main phone (text), Secondary phone (text), Email, None
- Where may we leave **medical information?** (Circle): Main phone (Vmail), Secondary phone (Vmail), Email, None

Present/Former Occupation: _____ Location: _____

Emergency Contact(s):

Name: _____ Relationship: _____ Phone #: _____

_____

INSURANCE

Primary Insurance: _____

Card ID# _____ Group: _____

Name on card: _____

Relationship: _____ DOB: _____

SSN: _____

Secondary Insurance: _____

Card ID# _____ Group: _____

Name on card: _____

Relationship: _____ DOB: _____

SSN: _____

MEDICAL RECORDS RELEASE

In the list below, include anybody (family members, physicians, etc.) you would like to have access to your medical information and history. By signing below, you authorize West Virginia Dermatology & Skin Surgery Center to disclose and/or release your medical information (pertaining to your diagnosis, treatment, laboratory results, medical history, etc.) to the individuals listed below. You authorize a copy of this signed document to be used in place of the original.

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

☐ **I would rather not add anybody**

Signature: _____

POLICIES AND STATEMENTS

Please read the following statements carefully and sign below. If you have questions regarding any of these, please discuss them with our office manager at 304-925-SKIN (7546). Thank you for choosing our office for your care!

All of the information I have provided in these forms is current, complete, and accurate. It is my responsibility to update information on file if it changes. My signature below will be used as my "signature on file" for comparing to other signatures where necessary. I permit a copy of this authorization form to be used in place of the original.

Treatment and Release of Medical Information

- I authorize my medical information to be released to West Virginia Dermatology, to my primary care physician's office, to my referring physician's office, and to insurance companies and their agencies (including Medicare) as needed for my treatment, or to process and file my medical claims.
- I authorize my treatments, anesthetics, and procedures to be administered by any of the physicians and staff of West Virginia Dermatology.

Late and No-Show Policy

West Virginia Dermatology is allowed to reschedule me if I am late. If I do not show up to an appointment, or if I cancel within 24 hours, I will be issued a no-show fee ($25 for a regular visit, or $150 if it was for a procedure or surgery) which my insurance will not cover. If I have two no-show appointments, West Virginia Dermatology will no longer see me as a patient. I may submit a written request for my medical records to be sent to another physician.

Insurance

- I am aware that my insurance policy is a contract between my insurance company and I only. It is therefore my responsibility to understand my outline, including my copayments, co-insurance, and any deductibles I may have. I am (or my accompanying party is) responsible for payments due at the time of service, and I am (or my responsible party is) ultimately responsible for everything my insurance will not pay. This includes anything my insurance declares "not medically necessary," "cosmetic," or "not covered," and payments they refuse to pay if I fail to notify West Virginia Dermatology of insurance changes before my appointment. I am aware that although my insurance benefits may be verified at the time of service, this does not mean that they will pay for the expenses.
- If my insurance is not in network with West Virginia Dermatology, or if I do not have insurance, I am responsible for my treatment and visit expenses at the time of service. West Virginia Dermatology would be happy to help me file a claim with my insurance company.
- I authorize my insurance payment benefits to be paid directly to West Virginia Dermatology.

Balances and External Charges

- Balances are due within 30 days of the date shown on the statement. West Virginia Dermatology will work with me on a payment plan if needed, but if these efforts do not resolve the balance, my account may be sent to a collection agency, in which case all fees charged by the collection agency would become my responsibility as well.
- If I need laboratory services (such as pathology or wound culture), the laboratory will give me a separate bill.

Dependents

- **Minors** must be accompanied by their legal parent/guardian, or have written permission from their legal parent/guardian to be brought to appointments by somebody else or be seen without an adult (if they are age 16 or older). Payments due at the time of service must still be paid by the accompanying party or by the patient.
- **Patients who have a Medical Power of Attorney (MPOA) and cannot make decisions or sign consent** must have their MPOA present and their MPOA papers scanned into their file before being seen.

Name: _____ **Date:** _____

Signature: _____

My signature shows that I have read, understand, and agree to all the statements and policies above.

Patient Name: _____ **DOB:** _____

MEDICAL CARE INFORMATION

Primary care physician: _____ Location: _____

Referring physician: _____ Location: _____

- Was a medical referral sent to us? Yes / No

Pharmacy: _____ Location: _____ Phone #: _____

Has someone been designated as the patient's **Medical Power of Attorney** (MPOA)? Yes / No

MPOA's Name: _____ Phone #: _____

MPOA's Address: _____ City: _____ State: _____ Zip: _____

Please provide a copy of MPOA papers. If patient cannot make decisions or sign consent, MPOA must be present.

Most recent… Height: _____, Weight: _____, Blood Pressure: _____ / _____

PERSONAL MEDICAL HISTORY: Circle all that apply, or circle NONE. For items marked **, please describe below.

Alzheimer's	Depression	Immunocompromised**
Anxiety	Dementia	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease (Kidney Failure)	Lymphoma
Autoimmune Disorder	Enlarged Prostate	Pacemaker
Atrial Fibrillation	GERD	Prostate Cancer
Bleeding Disorder**	Hearing Loss	Radiation Treatment
Bone Marrow Transplantation	Hepatitis, Type: _____	Seizures
Breast Cancer**	High Blood Pressure	Stroke
Clotting Disorder	HIV /AIDS	Thrombocytopenia
Colon Cancer	High Cholesterol	Valve Replacement:
COPD	Hyperthyroidism	(Mechanical or Biological?)
Coronary Artery Disease	Hypothyroidism	**NONE**

Other: _____

Please describe items marked with ** _____

SURGICAL HISTORY: Please circle all that apply, or circle NONE

Appendix removed	Kidney biopsy	Spleen removed
Bladder removed	Kidney removed (right, left)	Coronary artery bypass
Mastectomy (right, left, bilateral)	Kidney stone removal	Stents
Lumpectomy (right, left, bilateral)	Kidney transplant	Mechanical valve replacement
Breast biopsy (right, left, bilateral)	Ovaries removed: Endometriosis	Biological valve replacement
Breast reduction	Ovaries removed: Cyst	Heart transplant
Breast implants	Ovaries removed: Ovarian cancer	Skin biopsy
Colectomy: Colon cancer resection	Prostate biopsy	Basal cell cancer surgery
Colectomy: Diverticulitis	Prostate removed: Prostate cancer	Squamous cell carcinoma surgery
Colectomy: IBD	TURP	Melanoma surgery
Gallbladder removed	Testicles removed (right, left, bilateral)	**NONE**
Knee replacement (right, left, bilateral)	Hysterectomy: Fibroids	
Hip replacement (right, left, bilateral)	Hysterectomy: Uterine cancer	

Other joint replacement: _____

Other: _____

Surgery Complications: _____

_____

_____

_____

SKIN DISEASE HISTORY: Please circle all that apply, or circle NONE

Acne	Blistering sunburns	Hay fever / allergies	Psoriasis
Actinic keratoses	Dry skin	Melanoma	Squamous cell skin cancer
Asthma	Eczema	Poison ivy	**NONE**
Basal cell skin cancer	Flaking or itchy scalp	Precancerous moles	

Other: _____

Do you wear sunscreen daily? Yes / No -If yes, what SPF? _____

Do you use a tanning bed? Yes / No

MEDICATIONS: List, or attach a list, showing all current medications including Dosage and Frequency.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DRUG ALLERGIES: List, or attach a list, showing all allergies to medications.

_____

_____

_____

SOCIAL HISTORY: Please circle or checkmark all that apply.

Alcohol use:	Cigarette / Cigar smoking:	Do you use I.V. Drugs?
None	Never smoked	Yes / No
Less than 1 drink a day	Former smoker	If yes, what do you use?
1-2 drinks a day	Smoke less than daily	_____
3 or more drinks a day	Smoke daily	_____

FAMILY MEDICAL HISTORY: Please circle all that apply to your mother, father, brothers/sisters, daughters/sons.

Diabetes	Hyperthyroidism	Melanoma
Heart disease	Hypothyroidism	Psoriasis
Kidney disease	Bleeding disorders	Atopic dermatitis
High cholesterol	Stroke	Hay fever / allergies
Hypertension	Autoimmune disorders	Cancer: _____

Other: _____

REVIEW OF SYSTEMS: Please circle all that you are currently experiencing, or circle NONE

Problems with bleeding	Fever or chills	Abdominal pain	Headaches
Problems with healing	Night sweats	Bloody stool	Seizures
Problems with scarring	Unintentional weight loss	Bloody urine	Cough
Rash	Thyroid problems	Joint aches	Shortness of breath / Wheezing
Hay fever	Sore throat	Muscle weakness	Anxiety / Depression
Chest pain	Blurry vision	Neck stiffness	**NONE**

ALERTS: Please circle all that you are currently experiencing, or circle NONE

Allergic to adhesive	Pregnant or planning to be pregnant
Allergic to lidocaine	Perforated ear drum
Allergic to topical antibiotic ointments	Bleeding disorder
Artificial heart valve	Myasthenia gravis
Artificial joints within the past 2 years	Organ transplant
Blood thinners	Surgical scrub allergy
Defibrillator	Latex allergy
MRSA	Immunosuppression
Pacemaker	Implantable device (pain pump, stimulator, etc)
Premedication prior to procedure	Congenital heart disease
Rapid heartbeat with epinephrine	Thrombocytopenia or clotting disorder
Personal history of melanoma	**NONE**

Is the patient able to sign consent for surgeries / procedures? (Circle): Yes / No

Thank you!