FDL Dermatology, P.L.L.C.

Courtney Herbert, M.D., M.P.H.
1005 N Glebe Rd, Suite 540 Arlington, VA 22201
(703) 310-7400 / (703) 259-8735 (fax)

WE LOOK FORWARD TO HAVING YOU AS OUR PATIENT

Photo I.D. and current insurance card(s) are required at the time of your visit.

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME (Legal)	FIRST NAME (Legal)	MIDDLE INITIAL

STREET ADDRESS:	CITY	STATE:	ZIP:

HOME PHONE	WORK PHONE	CELL NUMBER	PATIENT'S DOB (REQUIRED)

sex M F	EMAIL:	EMPLOYMENT STATUS: (CIRCLE ONE) student working retired disabled

MARTIAL STATUS (CIRCLE ONE) single married divorced widowed	NAME OF PRIMARY CARE PHYSICIAN:

Were you referred by a physician? _____ Yes _____No	NAME OF REFERRING PHYSICIAN:

PERSON RESPONSIBLE FOR PAYMENT

LAST NAME (Legal)	FIRST NAME (Legal)	MIDDLE INITIAL

RELATIONSHIP TO PATIENT (Please circle one)

SELF SPOUSE FATHER MOTHER OTHER_____

We are a self-pay practice and we do opt out of Medicare but we ask that you please provide your insurance information for pathology and labs.

DEEMED CONSENT FOR DESIGNATED BLOOD BORNE PATHOGENS & CONSENT FOR MEDICAL CARE: I understand that Virginia law requires health care providers to notify me that Hepatitis B and C or HIV (AIDS) Virus testing on sample of my blood may be done if a health care worker is exposed to my blood or body fluids. I understand that this following notice is to advise me that this is in effect at this facility:

As health care providers under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for FDL Dermatology, P.L.L.C. is directly exposed to body fluids of a patient in a manner which , according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or hepatitis B or C, FDL Dermatology, P.L.L.C. will proceed to test the patient through his or her physician and the health care worker(s) who was/were exposed. When a person is tested, FDL Dermatology, P.L.L.C. automatically tests for hepatitis B and C for the safety of all concerned. I voluntarily consent to medical care at FDL Dermatology, P.L.L.C., which may include examination, tests, photographs and treatment by doctors and staff. No promises have been made to me as to the results of this treatment or examination

INITIAL:_____

INFORMATION RELEASE: I authorize FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D. to release to my Insurance Carrier any information needed to determine benefits payable to the related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D.

INITIAL:_____

Medicaid: I understand FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D. does not participate with Medicaid and I will be billed directly for charges incurred.

INITIAL:_____

Returned Check Fee: I understand that in the event that my check is returned for insufficient funds, I agree to provide cash, money order or certified check for the full amount of the payment owed, in addition to a $30.00 returned check charge.

INITIAL:_____

Missed Appointment Fee: I understand that I will be assessed a $50.00 fee if I miss an office visit without having provided a 24-hour advance notice of cancellation. I understand that I will be assessed a $100 fee if I miss a full body exam, surgical procedure, or cosmetic procedure without having provided a 48-hour advance notice of cancellation.

INITIAL:_____

Medical Records: I understand that I will be charged a fee to transfer my records to another physician or obtain a copy for myself: $15.00 for charts fifteen (15) pages or less in length, and $50.00 for charts exceeding fifteen (15) pages in length. This payment is due in full prior to the copying and forwarding of records.

INITIAL:_____

Refill Policy: I understand that it is FDL Dermatology, P.L.L.C. policy and practice to give patients enough medication to sustain them until their next visit; that follow up visit is required for prescriptions that are over one year old; and that depending on the situation, the patient may be given a one-time refill to carry them over until their next follow-up visit.

INITIAL:_____

As the responsible party, I understand and agree to the policies of FDL Dermatology, P.L.L.C. and Courtney Herbert, M.D. as stated in sections a, b, c, d, e, f, g, h, I, and j.

I understand that I am financially responsible for all services rendered.

Signature (Parent/Guardian, if patient is a minor) X _____

Date _____

MEDICAL HISTORY

Please fill out this form in its entirety.

Patient's Name:_____ Date:____/____/_____

Reason for today's visit: _____

Are you allergic to any medications? **YES** **NO** If "yes", list below and explain reason

Have you ever had dental anesthesia (Novocaine)? **YES NO** Any adverse reactions? **YES NO**

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals)

Do you have now, or have you ever had any of the following: (Please circle all that apply)

Skin:

- Melanoma
- Squamous Cell Carcinoma
- Basal Cell Carcinoma
- Merkel Cell Carcinoma
- Dysplastic/Atypical Mole
- Keloid Scar
- Psoriasis
- Dermatitis Herpetiformis
- Lupus
- Vitiligo
- Other:_____

Cardiovascular:

- High Blood Pressure
- Heart Attack
- Heart Murmur or Irregular Heartbeat
- Blood Clots
- High Cholesterol
- Anemia

Other Systemic:

- Asthma
- Emphysema
- Chronic Obstructive Pulmonary Disease
- Migraines
- Amputation
- Dialysis
- Nausea, Vomiting, Diarrhea when taking antibiotics
- Yeast infection when taking antibiotics
- Arthritis
- Convulsions, Epilepsy, or Seizures

Cancer:_____

Diabetes: Type_____

Thyroid:_____

Kidney:_____

Gastrointestinal: _____

List any other diseases or conditions:

List surgical procedures you have had in the last 12 months:

Do you have a family history of the following (if yes circle and state who):

Melanoma
Basal Cell Carcinoma
Squamous Cell
Carcinoma Merkel Cell
Carcinoma

Social History:

Do you drink alcohol:	**YES**	**NO**	If yes,_____drinks per day
Do you use IV drugs:	**YES**	**NO**	If yes, what?_____How often? _____
Do you smoke:	**YES**	**NO**	If yes, how much? _____
Are you a former smoker:	**YES**	**NO**	
Have you had or have you been exposed to HIV:		**YES**	**NO**
Have you been exposed to Hepatitis B or C:		**YES**	**NO**
(Women) Are you pregnant:	**YES**	**NO**	If yes, due date:____/____/____
Are you breastfeeding:	**YES**	**NO**	

What is your occupation:_____ Hobbies: _____

Your preferred pharmacy address and phone number (*phone number required)*:

How did you hear about our office?

SIGNATURE_____ DATE_____