BLUE VALLEY
DERMATOLOGY

**Patient Name:** _____ **Date of Birth:** _____

**BIRTH Sex: M/F** **Gender Identity - Identifies As: M / F / FTM / MTF / OTHER**

SSN:_____ Marital Status: Married / Single
Language:_____Race/Ethnic Group:_____
Home:_____Work:_____Cell:_____
Preferred Phone: Home/Work/Cell **Ok to leave a detailed message? Yes/No**
**OK for BVD to communicate via TEXT MESSAGE and/or EMAIL? Yes/No**
**I understand I can opt out at any time.**
Email:_____
Address:_____City:_____
State:_____ Zip Code:_____

**Responsible Party (if other than patient)**
Name:_____ Date of Birth: _____ Sex: M/F
Relationship to patient: _____
Phone: _____ Address: _____
Email: _____

**Insurance Policy Holder (if other than patient)**
Name:_____ Date of Birth: _____ Sex: M/F
Relationship to patient: _____
Phone: _____ Address: _____
Email: _____

**Emergency Contact**
Name:_____ Phone: _____
Relationship to patient: _____

**Insurance:**
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical insurance coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. Know that your copay is due at time of service. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. It is in your best interest to understand your insurance plan and ultimately you are responsible for knowing and understanding your coverage. Any balance left after insurance benefits have been paid are the responsibility of the patient.

# Consent for Medical Treatment, Minor Procedures and Communication

I understand that:

- During the course of my visit, my doctor may recommend that a procedure be performed. Such procedures include but are not limited to: liquid nitrogen destruction (freezing), biopsies, incision and drainage, scissor snip excision, curettage (scraping), electrodessication (use of cautery/heat), and steroid injection.
- The risks, benefits, and alternatives to these procedures will be explained at the time of my visit, prior to my doctor performing the procedure(s).
- I will be allowed to ask any questions that I have.
- Any and all procedures are optional. I may choose to decline a procedure for any reason.
- Photographs may be taken of me and kept in my medical file and will not be used in any other manner without my express written consent.
- There is no guarantee of results as medicine is not an exact science.
- Some procedures may need to be performed more than once to achieve optimum results.
- Procedures may incur additional charges, and I am responsible for payment.
- Both medical and cosmetic dermatologic services are provided in our office. It is important to understand that these services are billed separately and differently, even if you are seen for both medical and cosmetic reasons at the same appointment.
- If a procedure is deemed cosmetic, and therefore not covered by my insurance, my doctor will notify me of this fact and the associated charge prior to performing the procedure. I will be responsible for payment at the time of service.
- If I am scheduled for a cosmetic visit but mention a medical concern during my appointment, we will address your concern, as long as the schedule permits us to do so.
- The cost of a medical visit that is added to your bill during a scheduled cosmetic visit will NOT be included in the cost of your cosmetic visit and will be billed separately. As a courtesy, we will file applicable MEDICAL claims to your insurance company. Amounts not covered by your insurance are your responsibility.
- For more invasive procedures and certain cosmetic procedures, a separate consent may be required.
- All PROCEDURES have a NO SHOW/LATE CANCEL fee of $100. This will be charged to your account if you fail to show for a scheduled PROCEDURE APPOINTMENT or do not give at least 24 hours notice of cancellation or reschedule for your PROCEDURE appointment. Please understand that insurance companies consider this charge to be entirely the patient's responsibility.
- BVD communicates with its patients via phone, email, text messaging and through the Patient Portal. I understand that I may opt out of receiving emails or SMS text messages at any time.

**Assignment and Release:**

I authorize payments to be made directly to Blue Valley Dermatology (BVD) by my insurance company. I authorize the release of any medical care information requested by my insurance company. I accept financial responsibility for all services not covered by my insurance. I have read "Consent for Medical Treatment, Minor Procedures and Communication" and the Blue Valley Dermatology "Assignment and Release" statement. I consent to routine minor procedures and medical treatment and communication with BVD staff.

Printed Name of Patient: _____

Date of Birth of Patient:_____

Signature of Patient or Responsible Party: _____

Date: _____

# Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have read the Blue Valley Dermatology "Notice of Privacy Practices". These statements describe how my health information may be used or disclosed in order to receive benefits. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services. I understand that I may request a copy of the Notice at any time.

Printed Name of Patient: _____

Date of Birth of Patient:_____

Signature of Patient or Responsible Party: _____

Date: _____

**If you are not the patient, please fill out the following information:**

Printed Name: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

Telephone: _____

**People allowed access to my medical records:**

Name: _____Phone:_____Relationship:_____

Name: _____Phone: _____ Relationship:_____

Name: _____Phone: _____ Relationship:_____

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## *For our patients who completed their information on our Online Portal:*

**Your preferred phone number: _____ Home/Work/Cell**

**May we leave a detailed message at this phone number? Yes/No**

**Are you the Policyholder for Your Insurance? Y/N If No - Please list their information below.**

Name:_____ Date of Birth: _____ Sex: M/F

Relationship to patient: _____

# Medical History

**Patient Name:**_____ **Date of Birth:**_____
**Primary Care Doctor:** _____Phone: _____
**Referring Medical Professional:** _____ Phone: _____
**Reason for today's visit:** _____
Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
**Medications**: (Please enter all current medications, supplements and OTC medications; include strength and dosage if known)

**Allergies**: (Please list all allergies)

**Cigarette Use:** (Circle one) Never used Former user Current user No. packs per day No. of years

**Preferred pharmacy**: _____
Address _____ Phone#: _____
**Review of Systems**: Are you ***currently*** experiencing any of the following? (Please check yes or no)

| Symptom | Yes | No | Symptom | Yes | No |
|---|---|---|---|---|---|
| **Problems with bleeding** | | | **Active hepatitis C** | | |
| **Problems with healing** | | | **Abdominal pain** | | |
| **Problems with scarring** | | | **Bloody stool** | | |
| **Rash** | | | **Bloody urine** | | |
| **Immunosuppression** | | | **Joint aches** | | |
| **Hay fever** | | | **Muscle weakness** | | |
| **Chest pain** | | | **Neck stiffness** | | |
| **Fever or chills** | | | **Headache** | | |
| **Night sweats** | | | **Seizures** | | |
| **Unintentional weight loss** | | | **Cough** | | |
| **Thyroid problems** | | | **Shortness of breath** | | |
| **Sore throat** | | | **Wheezing** | | |
| **Ear pain** | | | **Anxiety** | | |
| **Blurry vision** | | | **Depression** | | |

**Past Medical History**: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD/Emphysema
Coronary Artery Disease
Depression

Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Disease

Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatments
Seizures
Stroke
NONE
Other_____
_____

**Skin Disease History**: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin

Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis

Squamous Cell Skin Cancer
NONE
Other_____
_____