BLUE VALLEY
DERMATOLOGY

Patient Name: _____ **Date of Birth:** _____**Sex: M/F**
SSN:_____ Marital Status: Married / Single
Language:_____Race/Ethnic Group:_____
Home:_____Work:_____Cell:_____
Preferred Phone: Home/Work/Cell **Ok to leave detailed message? Yes/No**
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 and Minor Procedures:

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.
- 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.
- For more invasive procedures and certain cosmetic procedures, a separate consent may be required.

Printed Name 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: _____

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 Policy Holder for Your Insurance? Y/N If No - Please list their information below.

Name:_____ **Date of Birth:** _____ **Sex: M/F**
Relationship to patient: _____

Assignment and Release:

I authorize payments to be made directly to Blue Valley Dermatology 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 and Minor Procedures" and I consent to routine minor procedures and medical treatment.

Acknowledgment of Receipt of Notice of Privacy Practices:

By signing below, I acknowledge that I have read the Blue Valley Dermatology Assignment and Release statement as well as the 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.

Printed Name 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:_____

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_____
_____