Phone: 540-885-4500 • Fax: 540-885-4600

PATIENT DEMOGRAPHIC INFORMATION
PLEASE PRINT

NAME:_____ AGE:_____
(LAST) (FIRST) (MIDDLE)

SEX: M F (CIRCLE) DATE OF BIRTH:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

MAILING ADDRESS:_____

_____
(CITY) (STATE) (ZIP CODE)

IF MAILING ADDRESS IS A POST OFFICE BOX, PLEASE GIVE PHYSICAL ADDRESS

HOME PHYSICAL ADDRESS:_____

PRIMARY PHONE #:_____ SECONDARY PHONE #:_____

EMAIL ADDRESS: _____

Would you like to receive our monthly emailed newsletter? ☐ *Yes!* ☐ *No thanks.*

MAY WE LEAVE A DETAILED MEDICAL MESSAGE ON YOUR PHONE? (PLEASE CIRCLE) Y N

PREFERRED METHOD OF APPOINTMENT CONFIRMATION: ☐ **PHONE CALL** ☐ **TEXT MESSAGE** ☐ **EMAIL**
*APPOINTMENT MESSAGES/TEXTS WILL BE LEFT ON THE PRIMARY PHONE NUMBER PROVIDED

EMPLOYER:_____ EMPLOYER PHONE:_____

FAMILY DOCTOR:_____ REFERRING DOCTOR:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

INSURANCE COMPANY: 1) _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER DOB: _____

INSURANCE COMPANY: 2) _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER DOB: _____

EMERGENCY CONTACT PERSON:_____

Relationship:_____ Phone:_____

Shenandoah Dermatology & Aesthetics

(Effective 11/29/2016)

SUMMARY OF FINANCIAL RESPONSIBILITY

Unless other arrangements are made, payment for visit is due at the time of the service (either full fee if you are paying privately, or your co-payment if we are billing your insurance company). Insurance is billed as a service to our patients. I understand that all charges not paid by my insurance carrier(s) remain my responsibility. Office staff is available to discuss potential payment issues with you.

Cancellation policy

Twenty-four hour notice is required for a cancellation of scheduled appointments. You may be subject to a charge of the following fees for appointments that you "no show": No show fee is $50.00.

You are at risk of losing your privilege to receive care at Shenandoah Dermatology if you "no show" for two consecutive appointments.

Please review the following:

- I understand the insurance may be filed for me, but I am ultimately responsible for payment of fees regardless of insurance coverage. I authorize the release of medical information required to process insurance claims and/or to complete Treatment Plans/Reviews as requested by insurance or managed care companies.
- I authorize payment for my insurance company to be made directly to the practice.
- I understand that I am responsible for obtaining proper (pre)authorization from my insurance company if necessary. I accept responsibility for payment if authorization is not obtained.
- I understand that I may be billed for any missed appointments unless I cancel at least 24 hours before my scheduled appointment. Charges for "no shows" are NOT covered by the insurance company.
- I understand that mailed monthly bills are due at the time of receipt. Any bill not paid will be turned over to a collection agency, unless other arrangements have been made. If my account becomes assigned to a collection agency, I agree to pay all cost of collection, including $30 collection fee, court costs and attorney fees.
- I agree that, in order for Shenandoah Dermatology to service my account or to collect any amounts I may owe, Shenandoah Dermatology may contact me by telephone at any telephone number associated with my account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, text or email, as applicable.
- Social security numbers are required for billing purposes in our office. I understand that if I choose not to disclose my social security number there will be a $75 charge due prior to treatment in the office. After insurance processing, I understand that I will be refunded any applicable credits.

HIPAA Policy

In addition to the above financial statement, I have reviewed a copy of the HIPAA privacy policy posted in the main office and can receive a copy at my request.

SSN: _____

Signature:_____ Date: _____

*If patient is a minor, parent/legal guardian must sign and we must have the guardian's SSN.

I hereby give my permission to disclose personal health information about my treatment to the following individuals: (Example: Spouse, parent/legal guardian, friend, etc.)

Name:_____ Phone#: _____ Relationship:_____

Name:_____ Phone#: _____ Relationship:_____

Name:_____ Phone#: _____ Relationship:_____

Shenandoah Dermatology & Aesthetics

Patient Name: _____
Date of birth: _____

HISTORY AND INTAKE FORM

PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY):

NONE
Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone marrow transplant – Year:_____
Cancer (Type: _____)
COPD
Depression
Diabetes
End-Stage Renal Disease
GERD
PCOS
Hearing loss
Hepatitis - Type if known:_____
HIV/AIDS
Hypertension
Overactive thyroid
Underactive thyroid
Leukemia
Coronary Artery Disease
Radiation treatment _____
Seizures
Stroke
Pacemaker/Defibrillator
Other _____

MAJOR SURGERIES (CIRCLE ALL THAT APPLY)

NONE
Knee replacement Right or Left
Colon surgery
Gallbladder removed
Heart surgery (Type: _____)
Hip replacement Right or Left
Hysterectomy Full or Partial
Lumpectomy Right, Left, Bilateral
Mastectomy Right, Left, Bilateral
Organ transplant (Organ: _____)
Ovaries removed
TURP
Testicles removed Right, Left, Bilateral
Other:_____

SKIN DISEASE HISTORY (CIRCLE ALL THAT APPLY)

NONE
Acne
Blistering sunburns
Dry skin
Eczema
Melanoma – Year: _____
Basal cell carcinoma – Year: _____
Squamous cell carcinoma – Year: _____
Poison Ivy rash
Psoriasis
Rosacea
Abnormal Moles
Actinic keratosis (pre-skin cancer)
Efudex/Fluorouricil
MOHs surgery

SOCIAL HISTORY (CIRCLE ALL THAT APPLY)

TOBACCO USE:
Current smoker
Daily
Not daily
Smoked in the past
Never smoked

ALCOHOL USE:
Social only
< 1 drink daily
1-2 drinks daily
≥ 3 drinks daily
None

ALERTS: (CIRCLE ALL THAT APPLY)
Artificial joint
Artificial heart valve
Blood thinners
Defibrillator
HIV/Hepatitis
Immunosuppressant
Pacemaker
Antibiotics prior to surgery

FAMILY HISTORY (Mother, Father, Sister, Brother, or Children)
Melanoma: _____
Rheumatoid arthritis: _____
Non-melanoma skin cancer: _____
Polycystic ovary disease: _____
Severe acne: _____

CURRENT MEDICATION LIST

Please note: If you have a list with you, please alert the front desk before filling out this form.

Patient name: _____ **Date of birth**: _____

Name of Medication	Dose/Strength	How often taken

DRUG ALLERGIES: **NO KNOWN DRUG ALLERGIES**

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Preferred pharmacy: _____

May we contact your pharmacy to obtain your prescription fill history? Y or N

(Please circle)