Phoenixville Valley Forge Dermatology Associates

First Name:_____ **Last Name:**_____ **DOB:**_____

Gender:_____ **Birthplace state or country:** _____ **Last 4 SS#:** _____

How would you like to be addressed? _____ **Reason for visit today?** _____

Please select from the list below any medical conditions you currently have or have had in the past.
(Please circle ALL that apply): NONE N/A

Anxiety
Arthritis
Asthma
Afib / Irregular heartbeat
Bone Marrow Transplant
Breast Cancer
Crohn's Disease
Colon Cancer
COPD / Emphysema
Coronary Artery Disease
Depression
Diabetes (I / II)
End Stage Renal Disease
GERD / Esophageal Reflux
Hepatitis (A / B / C)
Hypertension
HIV / AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures / Stroke
Ulcerative Colitis

Please list any other significant past medical history. (If none, please circle): NONE N/A

_____

Please list all past surgical history. (If none, please circle): NONE N/A

_____

_____

SKIN DISEASE HISTORY. (Circle all that apply): NONE N/A ☐ OTHER:

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sun Burn
Dry Skin
Eczema
Flaking / itchy scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer
Warts

☐ Yes ☐ No Do you wear sunscreen? If yes, what SPF? _____

☐ Yes ☐ No Do you use, or have you used a tanning bed? If yes, how frequently? _____

☐ Yes ☐ No Do you have a family history of skin cancer? If yes, please list family members and types of skin cancer.

_____

_____

PRESCRIPTION MEDICATIONS: (If none, please circle): NONE

NAME OF MEDICATION	DOSAGE	FREQUENCY

ALLERGIES: Please list all drug allergies and reactions. (**If none, please circle**): NKDA

_____

_____

Do you drink alcohol? (Please circle): None Less than 1 drink per day More than 1 drink per day

Do you smoke? (Please circle): Current Smoker Former Smoker Never smoked

OCCUPATION: _____

Are you currently pregnant or planning pregnancy in the near future? (Please circle): YES NO N/A

PRIMARY CARE PHYSICIAN.

Name: _____ City: _____ Phone#: _____

PHARMACY. (Local or mail order)

Pharmacy name: _____ City: _____ Pharmacy#: _____

PHONE MESSAGE CONSENT FORM

Notice of Privacy – Patient Acknowledgement

From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak to us directly, we would like to leave a message whenever possible. To assist us in protecting your privacy, please complete the following:

May we leave a detailed voice mail message regarding lab results and/or biopsy results?
(Please circle): YES NO

May our billing department leave a message regarding your account? (Please circle): YES NO

Please list the best phone numbers for us to contact you.

Primary Phone#: _____ (Cell / Home / Work / Other)

Alternate Phone#: _____ (Cell / Home / Work / Other)

May we speak to someone else regarding your medical care? YES NO

Name of person: _____ Relationship: _____

Name of person: _____ Relationship: _____

Email Address (Optional): _____

By signing below, I acknowledge that I have been provided the Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information, and I was given an opportunity to read the notice. I understand I may revoke this consent at any time.

Signature: _____ Date: _____

Relationship to patient (if applicable): _____

Do you have a power of attorney (POA)? (Please circle): YES NO

If yes, Name: _____ Relationship: _____

Phone number: _____

FINANCIAL POLICY

We at Phoenixville Valley Forge Dermatology and Associates, PC are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about this financial policy.

You agree to allow Phoenixville Valley Forge Dermatology Associates the right to service your account or collect monies you may owe. Our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We also may contact you for marketing purposes via email if you provided us with an email address. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Collection Policy and Agency Fees:

After services have been rendered and your insurance carrier has processed your claim, if there are any balances due you will have the option to pay in full or set up a payment plan. If arrangements have not been made to pay your outstanding balance after the third mailed statement, we will submit your account to our collection agency.

Agreement To Pay: If my account were to go to collections, I, the undersigned accept the fee charged (25% of the balance due) as a legal and lawful debt and agree to pay said fee.

I/We have read this disclosure and policies and agree with the above.

_____ _____

Responsible Party Signature Date

_____

Date of Birth

PHOENIXVILLE/VALLEY FORGE DERMATOLOGY ASSOCIATES

CANCELLATIONS / NO SHOWS FOR ALL MEDICAL AND SURGICAL APPOINTMENTS

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

We ask that if possible you call to cancel at least 24 hours in advance of your scheduled appointment.

There will be no charge for cancellations.

No shows will result in a twenty-five-dollar ($25.00) charge; this will not be covered by your insurance.

Payment of this fee will be required **prior** to your next office visit.

Print Patient Name	Date of Birth
Patient Signature / Guardian Signature	Date