



PHOENIXVILLE DERMATOLOGY ASSOCIATES

1260 Valley Forge Road Suite 101

Phoenixville, PA 19460

Phone 610-983-3980

Fax 610-983-3406

Patient Name: _____ D.O.B: _____ Sex: _____
 Birthplace (state and country): _____ Last 4 Digits of SSN: _____
 How would you like to be addressed: _____ Reason for today's visit: _____
 Email Address: _____

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 | Coronary Artery Disease | Hyperthyroidism |
| Arthritis | Depression | Hypothyroidism |
| Asthma | Diabetes | Leukemia |
| Afib/Irregular Heartbeat | End Stage Renal Disease | Lung Cancer |
| Bone Marrow Transplant | GERD/Esophageal Reflux | Lymphoma |
| Breast Cancer | Hepatitis | Prostate Cancer |
| Crohn's Disease | Hypertension | Radiation Treatment |
| Colon Cancer | HIV/AIDS | Seizures/Stroke |
| COPD/Emphysema | High Cholesterol | 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 HISTORY DISEASE (Circle all that apply). NONE N/A OTHER

- | | | |
|------------------------|---------------------------|-------|
| Acne | Melanoma | _____ |
| Basal Cell Skin Cancer | Poison Ivy | _____ |
| Blistering Sun Burn | Precancerous Moles | _____ |
| Dry Skin | Psoriasis | _____ |
| Eczema | Rosacea | _____ |
| Flaking/Itchy Scalp | Squamous Cell Skin Cancer | _____ |
| Hay Fever/Allergies | Warts | _____ |

Do you wear sunscreen? YES NO SPF: _____

Do you use or have you used a tanning bed? YES NO How frequently? _____

Do you have a family history of skin cancer? YES NO 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? (Circle one): None Less than 1 drink per day More than 1 drink per day
Do you smoke? (Circle one): Current Smoker Former Smoker Never smoked

OCCUPATION: _____

Are you currently pregnant or planning a pregnancy? 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 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 Number _____ (Cell/ Home/ Work)

Alternative Phone Number _____ (Cell/ Home/Work)

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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 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

Signature

Date of Birth