Semler Dermatology, Inc.

New Patient / Patient Update Information Sheet

Name:_____Date of Birth:_____
Address:_____City/State/Zip:_____
Email:_____ Sex: M F Marital Status:_____
Patient's Employer: _____Occupation:_____
Phone(Home)_____(Cell)_____(Work)_____
Responsible party (if patient is a minor)_____

Did your doctor or other medical provider request this consultation today? YES NO
If you answered YES what is the name of the provider?_____
Primary Doctor:_____

PRIMARY INSURANCE COVERAGE

Primary Insurance:_____ ID#_____Grp#_____
Subscriber *(if different than patient)*_____Subscriber's DOB:_____
Subscriber Address (if different):_____
Secondary Insurance: _____ID#_____Grp#_____
Subscriber (*if different than patient*)_____Subscriber's DOB:_____
Subscriber Address (if different):_____

Pharmacy (include City or street):_____
Emergency contact:_____Phone:_____

We will bill your insurance company if we participate with that company. You are responsible for any and all charges that your insurance company does not cover such as deductibles, co-pays and non-covered services, which are payable at the time of service. For your convenience, we accept Visa and MasterCard. Parents are responsible for payments on child accounts. All tissue removed will be sent for pathologic examination. I authorize for insurance payments to go directly to physician and for release of necessary medical records to the insurance company to receive payment.
HMO participants: In order for your insurance to pay for your visit, it is ***your*** responsibility to obtain referrals from your primary care physician for **each visit.** I have had the opportunity to review the corporation's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I certify that I understand the above and that the information I have given is correct to the best of my knowledge. **I have read and reviewed the outside billing agency policy.**

Please provide the name of person(s) to whom you would permit Semler Dermatology to disclose personal health information as necessary for your continued health care**:**

_____ _____ _____

Cancellation Policy: Patients who do not give at least 24 hour cancellation for a scheduled appointment are subject to a $50.00 fee for office visits and $100.00 for procedures.

_____ _____
Patient Signature (if patient is a minor, signature of parent or guardian is required) Date

19465 Deerfield Avenue, Suite 408, Lansdowne, VA 20176 703.723.6568

New Patient History

Welcome to the office of Semler Dermatology, Inc. This form is a permanent part of your medical record. Please complete this form as carefully and completely as possible.

Name: _____

What is the reason for your visit?

PAST MEDICAL HISTORY and/or CURRENT MEDICAL PROBLEMS: Please list any and all dermatologic or medical conditions that you have had or currently have (i.e. skin cancer [melanoma or other type], abnormal mole [atypical or dysplastic], heart disease, pacemaker, high blood pressure, high cholesterol, diabetes, asthma, arthritis, or any type of cancer).

Medication allergies:

Do you take aspirin or any other blood thinners? Yes No			
Current Medications:			Supplements / Herbals:
Name	Strength	How often	

(Continued on next page)

Name: _____

Prior surgeries:
Do you have a pacemaker? Yes No
Do you have any artificial joints? Yes No
Do you have any artificial heart valves? Yes No

Dermatologic Family History:
(please make a check mark if members of your family have/had these conditions:

	Mother	Father	Sister	Brother	
Asthma					
Atypical (dysplastic) moles					
Diabetes					
Eczema					
Melanoma					
Psoriasis					
Skin cancer (Non-Melanoma)					

Do you drink alcohol?
Do you smoke?
Do you use sunscreen? Always Sometimes Never
History of tanning bed use? In the past Current

For Women: Are you currently -
Pregnant? Yes No
Trying to become pregnant? Yes No
Nursing? Yes No

Information regarding outside billing agencies

Often during dermatological examination, skin or other tissue may need to be removed for pathologic examination ("biopsy").

If this occurs during your visit today or at future visits, the specimen will be sent to an outside pathology laboratory for analysis. The lab that your specimen goes to depends on your insurance.

The pathology interpretation is made by another physician ("pathologist") and subsequently there is an additional charge from that physician and laboratory. These bills are NOT coming from our billing department. They will be billing your insurance company independently from us. This is not a specific policy of our office, just an explanation of the process for any office that sends out tissue for analysis.

We are happy to address any questions you may have regarding this process.

I have read and reviewed the above statement and understand the billing policy.

_____
(Printed Name of Patient)

_____
(Signature of Patient or Parent/Guardian)

_____
(Date)

Receipt of Notice of Privacy Practices

I am a patient of Semler Dermatology, Inc. I hereby acknowledge receipt of Semler Dermatology, Inc.'s Notice of Privacy Practices.

Name [please print]: _____

Date of Birth:_____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____[patient name]. I hereby acknowledge receipt of Semler Dermatology, Inc.'s Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Date of Birth:_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____