VALLEY DERMATOLOGY, LLC

2611 West Main Street, Ste 1
Waynesboro, VA 22980
540-221-6702
Fax: 540-221-6704

PATIENT DEMOGRAPHICS

Patient Name:_____

DOB:_____ Social Security Number:_____

Guarantor:_____

Mailing Address_____

_____

Physical Address (if different from above)_____

_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Marital Status:_____

Employee Status:_____ Employer:_____

Primary Care Physician:_____

Referring Physician:_____

Insurance:1)_____2)_____

DOB of cardholder:_____

Emergency Contact:_____ Phone:_____

EMAIL address:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is a summary only. You may request a detailed account of our privacy policy from our front desk personnel.

- **HOW WE MAY USE AND DISCLOSE YOUR HEATLH INFORMATION**. We use health information about you for treatment, payment and for administrative purposes, and to evaluate the quality of care that you receive. Our office policy engages rules to detect, prevent and mitigate identity theft in connection with new and existing accounts. Beyond these situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses or disclosures.
- **YOUR RIGHTS.** You have the right to look at or get a copy of your health information that we use to make decisions about you. We ask for a preliminary request and legally we have 10 business days in which to respond. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect, or information is missing, you have the right to request that we correct the existing information or add the missing information. The medical record of your care legally belongs to the Practice.
- **OUR LEGAL DUTY**. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.
- **PRIVACY COMPLAINTS**. If you are concerned that we have violated your privacy rights, our privacy policies, or you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to:

U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201

If you have any questions or complaints, please contact
Marilyn Johnson, Practice Administrator,
Valley Dermatology, 2611 West Main Street, Ste 1
Waynesboro, VA 22980. (540) 221-6702.

I have received this summary notice of the Privacy Practices of Valley Dermatology.

_____ _____
Signature of patient (Parent/Legal Guardian of minor) Date

_____
Chart Number

VALLEY DERMATOLOGY, LLC

Disclosures to Family Members and Friends

Patient Name: _____

I hereby give my permission to disclose personal information about my treatment to the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

May we leave a personal medical information on your answering machine at home: YES NO

SUMMARY OF FINANCIAL RESPONSIBILITY

- I authorize Valley Dermatology, LLC to file my insurance carrier(s), but I understand any charges not paid by my insurance carrier(s) remain my responsibility.
- I authorize the release of medical information required to process insurance claims and/or to complete treatment plans/reviews as requested by insurance.
- I authorize payment for my insurance company to be made directly to Valley Dermatology, LLC.
- 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 agree that, in order for Valley Dermatology, LLC to service my account or to collect any amounts I may owe, they 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, as applicable
- I understand that 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, court costs and attorney fees.

_____ _____

Patient/Guardian Signature Date

HISTORY AND INTAKE FORM: **NAME:**_____

Last Flu Vaccine:_____

Last Pneumonia Vaccine:_____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer /Last Mammogram:_____
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Other_____

Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

_____ __

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection, Diverticulitis
Spleen Removed
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement (Knee, Hip) (Right, Left, Bilateral)
Kidney Biopsy
Kidney Removed (Right, Left)

Kidney Stone Removal
Kidney Transplant
Kidney Transplant
Ovaries Removed :Endometriosis, Cyst, Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate biopsy
TURP
Testicles Removed (Right, Left, Bi)
Hysterectomy: Fibroids, Uterine Cancer
NONE
Other_____
_____
_____

PATIENT NAME:_____

SKIN DISEASE HISTORY: (please circle all that apply)

Acne	Hayfever
Actinic Keratoses	Melanoma
Poison Ivy	
Basal Cell Skin Cancer	Precancerous Moles
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	None
Flaking or Itchy Scalp	

Other_____

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? _____

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: Former smoker
- Smokes less than daily
- Smokes daily

Illicit Drug Use:
- None
- Drug Use
- IV Drug use

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:
- I feel safe at home.
- I do not feel safe at home.

Other: _____

Medication List

Patient Name:_____

Preferred Pharmacy:_____ Location:_____

1. Prescription Drugs
2. Over the Counter Products (Pain relievers, antihistamines, lotions, laxatives, etc)
3. Supplements (Herbal, Vitamin or Mineral and Dietary)

Medication Name	Dosage	How Often

Drug Allergies:

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

NKDA: No Known Drug Allergies

Please Use Back of Paper for Additional Space