

LOUDOUN DERMATOLOGY ASSOCIATES

Account Number

PATIENT INFORMATION

Last Name	First Name	Middle Initial
Street Address	City/State	Zip Code
Home Telephone	Emergency Telephone	Emergency Contact
Social Security Number	Date of Birth (mm,dd,yy)	Sex: Male / Female
Primary Care Doctor	Preferred Pharmacy Name/Phone Number	School Name/Phone Number (if applicable)
Employer	Employer Address/Phone Number	Single / Married / Divorced / Widowed

RESPONSIBLE PARTY/BILLING INFORMATION

Last Name	First Name	Middle Initial
Street Address (if different from above)	City/State	Zip Code
Home Telephone	Employer Phone	
Employer	Employer Address	
Social Security Number		

PRIMARY INSURANCE INFORMATION

Name of Company	Office Co-Pay \$	Insurance Telephone
Group Number	Policy Number	
Insurance Address	City/State	Zip Code
Insured's Name	Date of Birth	Relationship
Insured's Employer	Address/State/Zip Code	Social Security Number
		Telephone

SECONDARY INSURANCE INFORMATION

Name of Company	Insurance Telephone
Group Number	Policy Number
Insurance Address	City/State
Insured's Name	Date of Birth
Insured's Employer	Address/State/Zip Code
	Relationship
	Social Security Number
	Telephone

PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG,PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC, or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

Signature

Date

How did you hear about our Medical Center? • Yellow Pages • Referral Service • Physician • Emergency Room • Welcome Packet • Family/Friend • Hotel • Employee • Health Fair/Trade Show • Direct Mail • Managed Care Plan/Insurance Company • Newspaper • Other _____

Patient's Medical History

Referring Doctor:

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Reason for today's visit: _____

Skin cancer screening today? (CIRCLE): Complete Above-waist Decline

Are you **allergic** to any medications or had an ill reaction to local (dental) anesthesia? **NO** If **YES**, please list:

List all medications you are currently taking (INCLUDE PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, AND HERBALS): **NONE**

COMPLETE BOTH COLUMNS & CIRCLE APPROPRIATE CHOICES

Medical History and Review of Systems: Do you have now, or previously had conditions of (CIRCLE):

<input type="checkbox"/> Y	<input type="checkbox"/> N	Lungs (CIRCLE) wheezing, shortness of breath, coughing, bronchitis, Emphysema, Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Constitutional (CIRCLE) fevers, chills, night sweats, poor appetite, weight loss
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular (CIRCLE) high blood pressure, heart attack, chest pain, heart murmur, arrhythmia, blood clots, bleed easily, legs swelling, mitral valve prolapse, artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	PACEMAKER / DEFIBRILLATOR	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease (WHAT KIND? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (WHAT KIND? _____)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease (WHAT KIND? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal (CIRCLE) nausea, vomiting, diarrhea, Crohn's / ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	Are you on dialysis ?
<input type="checkbox"/>	<input type="checkbox"/>	History of STD's (CIRCLE) genital warts / herpes, molluscum, syphilis, gonorrhea (OTHER? _____)	<input type="checkbox"/>	<input type="checkbox"/>	Bladder / Prostate incontinence, dark urine, prostate disease(CIRCLE)
<input type="checkbox"/>	<input type="checkbox"/>	HIV, Hepatitis B or Hepatitis C? (CIRCLE)	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal / Rheumatologic (CIRCLE) arthritis, limited motion, artificial joint, Lupus, Rheumatoid Arthritis
			<input type="checkbox"/>	<input type="checkbox"/>	Neurological / Psychiatric (CIRCLE) headaches, dizziness, seizures, fainting, depression, anxiety
			<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose, Throat (CIRCLE) Eyes: burning, itching, grittiness, glaucoma, cataracts Nose: nasal polyps, hay fever, Mouth: canker sores, cold sores (OTHER? _____)

Skin: Have you ever had skin cancer? YES NO
When exposed to sunlight, do you usually BURN BURN & TAN TAN Do you use sunscreens? Y N
Do you have a history of a specific skin disease? YES NO if yes, _____

List any **other** diseases or conditions or clarify any of the above: _____

List any **surgical procedures** you have had in the last 6 months: _____

Social History:

What is your **occupation**? _____

Do you drink **alcohol**? YES NO Do you use **recreational drugs**? YES NO
Do you use **tobacco products**? YES NO What kind? _____

Women: Are you pregnant or trying to conceive? YES NO How many weeks? _____ Due Date: _____
Are you currently breastfeeding? YES NO

Family History:

 Please circle or list any relevant family medical history (skin or otherwise):

Allergies	Diabetes	High blood pressure	Psoriasis
Arthritis	Eczema	Hives	Melanoma
Asthma	Hay fever	Lung disease	Skin cancer
Cancer	Heart disease	Lupus	Tuberculosis

PLEASE SIGN AND DATE BELOW WHEN COMPLETE

Completed by: _____ Date: _____ Medical Staff: _____ (INITIALS)
Patient or Guardian Signature

Reviewed by: _____ Date: _____
Physician Signature

Cancellation Policy

The doctors and staff appreciate your patronage and look forward to caring for you, our patients. We strive to accommodate all of our patients needs and respect that you, too, have a busy schedule. An unfortunate reality is that sometimes people make appointments and do not show up, or give us insufficient notice. To ameliorate this, we are instituting the following office policies:

Cancellations or rescheduling with less than 24 hours notice or failing to show at the designated appointment time will incur an administrative fee:

- Missed office visit: **\$25**
- Missed surgery appointment: **\$50**
- Missed elective or cosmetic procedure: \$100

No show for elective or cosmetic procedure will be charged full service price

We make all efforts to prevent these measures by double-checking at the time the appointment is made that there is no misunderstanding. We always call with two or more days of sufficient notice to allow time for you to make arrangements to arrive, or to cancel with 24 hours notice.

By signing below, you agree to adhere to these policies. These will likely never apply to you.

With regards,

Dr. Van T. Ha, M.D.

Dr. Roberta M. Moreland, M.D.

Patient Signature

Date