Access Dermatology & Spa

563-A Neff Avenue,
Harrisonburg, VA 22801
Phone: 540-434-1756
Fax: 540-434-1840

PATIENT INFORMATION – PLEASE PRINT

NAME____ **AGE** ________
(LAST) (FIRST) (MIDDLE)

GENDER: ☐ MALE ☐ FEMALE ☐ NON-BINARY **DATE OF BIRTH** _____________SOCIAL SECURITY NUMBER___________

PERSON RESPONSIBLE FOR ACCOUNT BALANCE____

MAILING ADDRESS____
(CITY) (STATE) (ZIP CODE)

BILLING ADDRESS (if different from mailing)____
(CITY) (STATE) (ZIP CODE)

HOME PHONE____________________**WORK PHONE**_________________**CELL PHONE**______________________

Which phone is best to reach you on or to leave a message? ____

EMAIL ADDRESS: ____

_____ **I DO NOT WANT** **TO RECEIVE MESSAGES REGARDING COSMETIC PRODUCTS AND SERVICES**

IF MAILING ADDRESS IS A POST OFFICE BOX - PLEASE GIVE PHYSICAL ADDRESS

PATIENT'S/GUARDIAN'S EMPLOYER_______________________________**EMPLOYER'S PHONE** ______________

HOME PHYSICAL ADDRESS____

FAMILY DOCTOR_________________________________PHONE FAMILY DOCTOR _____________________

REFERRING DOCTOR:____

MARITAL STATUS: ☐ *SINGLE* ☐ *MARRIED* ☐ *WIDOWED* ☐ *DIVORCED* ☐ *SEPARATED*

EMPLOYEE STATUS: ☐ *FULL-TIME* ☐ *PART-TIME* ☐ *NOT EMPLOYED* ☐ *SELF EMPLOYED* ☐ *RETIRED*

STUDENT STATUS: ☐ *FULL-TIME* ☐ *PART-TIME* ☐ *NOT A STUDENT*

INSURANCE COMPANY 1)_______________________________2) _______________________________

POLICY HOLDER'S NAME______________________________**POLICY HOLDER DOB** __________________

EMERGENCY CONTACT PERSON____

Relationship____________________________________**PHONE**__________________________________

I hereby give my permission to disclose personal information about my treatment to the following individuals:
(Example: Spouse, parent/legal guardian, friend, etc.) **We may only give information to listed individuals (including parents & spouses). If no one is listed Access Dermatology CANNOT give any information about you.**

Name:__________________________ Phone: ___________________ Relationship:___________________

Name:__________________________ Phone#: __________________ Relationship: __________________

____ YES, I acknowledge that anyone not listed above will be unable to communicate with Access Dermatology on my (or my child's) behalf. **WE MUST BE ABLE TO COMMUNICATE WITH THE ACCOUNT GUARANTOR REGARDING BILLING MATTERS**

*____ ______________________
Patient Signature **Date**
(Or Parent/Legal Guardian of Minor)

May we leave personal medical information on your home answering machine or cell phone voicemail?
___YES ___NO
May we contact you about upcoming appointments or follow-up reminders via email and/or voicemail?
___YES ___NO

YOUR PREFERRED CONTACT METHOD for RECALLS/FOLLOW-UPS:
EMAIL______ **PHONE**_______ **U.S. MAIL**______

I have read and agree to the Notice of Privacy Practices provided to me by Access Dermatology, PC.

*____________________________________ ______________________
Patient Signature **Date**
(Or Parent/Legal Guardian of minor)

I have read and agree to the Financial Policy provided to me by Access Dermatology, PC.

*____________________________________ ______________________
Patient Signature **Date**
(Or Parent/Legal Guardian of minor)

AUTHORIZATION AND CONSENT TO TREAT

I, the undersigned, authorize Mary Mather, MD to provide medical care to me or my minor dependent. I, the undersigned, authorize release of any medical information or other information necessary to process insurance claims for myself or my minor dependent. I, the undersigned, request that payment of authorized Medicare and/or other insurance benefits be made, for me or on my behalf, to Access Dermatology, PC, for any services furnished by that physician/provider. I authorize any holder of medical information about me to release to my insurance carrier and/or the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits are payable for related services.

*____________________________________ ______________________
Patient Signature **Date**
(Or Parent/Legal Guardian of minor)

Print Patient name____ **DOB** ___________________

HISTORY AND MEDICAL INTAKE FORM

Past Medical History (Circle all that apply or circle NONE)

NONE
Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation **Year________**
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Other__________________________

Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker - **Year _____________**
Prostate Cancer
Radiation Treatment - **Year ___________**
Seizures
Stroke
Valve Replacement

Past Surgical History (Circle all that apply or circle NONE)

NONE	**Circle Which One**	**Year**		**Circle Which One**	**Year**
Appendix Removed			Kidney Biopsy		
Basal Cell Cancer Surgery			Kidney Removed	Right, Left	
Bladder Removed			Kidney Stone Removal		
Breast Biopsy	Right, Left, Bilateral		Kidney Transplant		
Breast Reduction			Knee Replacement	Right, Left	
Breast Implants			Lumpectomy	Right, Left, Bilateral	
Colectomy: Colon Cancer Resection			Mastectomy	Right, Left, Bilateral	
Colectomy: Diverticulitis			Melanoma Surgery		
Colectomy: IBD			Ovaries Removed: Endometriosis	Right, Left	
Coronary Artery Bypass			Ovaries Removed: Cyst	Right, Left	
Gallbladder Removed			Ovaries Removed: Ovarian Cancer	Right, Left	
Heart Valve Replacement			Prostate Biopsy		
Heart Transplant			Prostate Removed: Prostate Cancer		
Hip Replacement	Right, Left		Spleen Removed		
Hysterectomy: Fibroids			Squamous Cell Cancer Surgery		
Hysterectomy: Uterine Cancer			Testicles Removed	Right, Left, Bilateral	
Other: ______________________			TURP		

Medications (please list all current prescriptions as well as over-the-counter medications that you currently take----you may submit a list if available) Circle here if - NONE

Medicine	Dosage	For
______________________	___________	______________________________________
______________________	___________	______________________________________
______________________	___________	______________________________________
____________________	___________	______________________________________
______________________	___________	______________________________________

Print Patient name____ **DOB ___________________**

Medication Allergies (please list allergy and reaction, or attach a list): **Circle here if NONE**

___________________________ ________________________
___________________________ ________________________
___________________________ ________________________

Social History: (Please circle all that apply)

Tobacco use:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily
Smokeless/Snuff

Alcohol Use:

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

Skin Disease History: (please circle all that apply)

NONE
Acne
Actinic Keratosis
Asthma
Eczema
Basal Cell Skin cancer: **Year_____Where______**
Blistering Sunburns
Dry Skin
Hay Fever/Allergies
Melanoma: **Year_______Where ______________**
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer: **Year____Where___**

Do you wear Sunscreen? Yes No
If yes, what SPF? ____________
Do you tan in a tanning salon? Yes No

FAMILY HISTORY (list affected 1st degree relative: Mom, Dad, Sister, and Brother)
Circle if NONE

Melanoma____
Diabetes____
Breast cancer______________________________________
Heart disease______________________________________
Lupus or Rheumatoid Arthritis_________________________
Colon cancer_______________________________________

FEMALE PATIENTS: Are you currently pregnant? YES NO Planning pregnancy? YES NO

Are you nursing? YES NO

Name of your preferred PHARMACY____
Location or phone number____

Print Patient name____ **DOB ____________________**