WELCOME

Virgin Islands Dermatology, Inc
9150 Estate Thomas, Suite 106
St. Thomas, VI 00802

1. PATIENT INFORMATION *(Please Print)*

Today's Date ____/____/____

Name _____
Last *First* *M.I.*

Mailing Address _____
City *State* *Zip*

Physical Address _____
City *State* *Zip*

E-mail Address _____ Cell Phone _____
Area Code

Home Phone _____ Work Phone _____ SS# _____
Area Code *Area Code*

Date of Birth ____/____/____ Age _____ Sex _____ Marital Status _____

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name _____
Last *First* *M.I.*

Address _____
City *State* *Zip*

Home Phone _____ Work Phone _____ Cell Phone _____
Area Code *Area Code* *Area Code*

SS# _____ Date of Birth ____/____/____ Sex _____

2. INSURANCE INFORMATION *(Please present insurance card at time of check in.)*

Primary Insurance Name _____
Ins. Address _____
Name of Insured _____
Insured's ID# _____
Insured's D.O.B. _____
Group # _____
Employer Name _____
Employer Address _____
Employer Phone _____
Area Code
Relationship of patient to the Insured _____

Secondary Insurance Name _____
Ins. Address _____
Name of Insured _____
Insured's ID# _____
Insured's D.O.B. _____
Group # _____
Employer Name _____
Employer Address _____
Employer Phone _____
Area Code
Relationship of patient to the Insured _____

Other family members that are patients _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by: _____

Primary Care Physician _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ____/____/____

We appreciate your business. In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a health insurance plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, an administrative fee of $25.00 will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ____/____/____

☐ **Copy of insurance card (both sides) attached.** ☐ Updated By: _____

Dermatological Medical History

3. Patient _____ Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO if yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocain)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Trouble Breathing	☐	☐
Chronic Cough	☐	☐
Shortness of Breath	☐	☐
Cardiovascular:	YES	NO
Chest Pain	☐	☐
Heart Disease	☐	☐
History of Blood Clots	☐	☐
Pacemaker	☐	☐
Gastrointestinal:	YES	NO
Nausea, vomiting, diarrhea	☐	☐

Other Systemic:	YES	NO
Yeast infection when taking antibiotics	☐	☐
Headaches	☐	☐
Excessive thirst	☐	☐
Vision Problems	☐	☐
Frequency/burning	☐	☐
Pain in Joints	☐	☐
Limited Motion	☐	☐
Dizziness	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 5 years: _____

4. Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**
☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

5. Skin

Have you ever had skin cancer? ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO
Do you have a history or any specific skin diseases? ☐ YES ☐ NO If yes, _____
Do you have problems with healing? ☐ YES ☐ NO
Do you develop keloids (scars) after surgery? ☐ YES ☐ NO
Do you bleed easily? ☐ YES ☐ NO
I develop skin rashes in reaction to: ☐ Medications ☐ Food ☐ Environment

6. Social History

Do you drink alcohol? ☐ YES ☐ NO If yes, how many per day, week or month? _____
Do you use IV drugs? ☐ YES ☐ NO If yes, What? _____ How often? _____
Do you smoke? ☐ YES ☐ NO If yes, how much? _____
Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO
Are you pregnant (women only)? ☐ YES ☐ NO Due Date ____/____/____
What is your occupation: _____ Hobbies: _____

Completed by: ☐ *Patient* ☐ *Medical Assistant* _____ *Initials*

_____ ____/____/____
Patient Signature *Date*

_____ ____/____/____
Reviewed by *Date*

VIRGIN ISLANDS DERMATOLOGY, INC.

9150 ESTATE THOMAS, SUITE 106
ST. THOMAS, VI 00802

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for *Virgin Islands Dermatology, Inc*_to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). *Virgin Islands Dermatology, Inc*_Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. *Virgin Islands Dermatology, Inc* reserves the right to revise its Notice, of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Virgin Islands Dermatology, Inc*_Privacy Officer at *9150 Estate Thomas. Suite 106, V.1. Med. Foundation Bldg. St. Thomas, VI 00802.*

With this consent, *Virgin Islands Dermatology, Inc*_may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, *Virgin Islands Dermatology, Inc*_may mail to my home or other alternative location any items that assist the practice in carrying out TPO. Such as appointment reminder cards and patient statements if they are marked Professional and Confidential.

With this consent *Virgin Islands Dermatology, Inc*_may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that *Virgin Islands Dermatology, Inc* restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to *Virgin Islands Dermatology, Inc's* use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, *Virgin Islands Dermatology, Inc*_may decline to provide treatment to me.

_____ _____

Signature - Patient or Legal Guardian Date

_____ _____

Patient's Name Print - Patient or Legal Guardian

VIRGIN ISLANDS DERMATOLOGY, INC.

9150 ESTATE THOMAS, SUITE 106
ST. THOMAS, VI 00802
TEL: 340-776-2544
FAX: 340-774-2677

Financial Responsibility

Patient Name: _____

Name of person responsible for this account: _____

Mailing Address: _____

Patient's Social Security Number: _____

Responsible Person's Social Security Number:

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to Dermatology & Wellness Center, LLC. I also understand that my insurance plan may not cover these procedures, and in that event, I will take full responsibility for all outstanding fees.

I further understand that should this account become delinquent and it becomes necessary for the amounts to be referred to an attorney or collection agency for collection or suit, I, as the designated responsible person, shall pay the reasonable attorney fees or collection expenses.

_____ _____

Patient or Responsible Person's Signature Date