PHOENIXVILLE
DERMATOLOGY ASSOCIATES

1260 Valley Forge Road Suite 101
Phoenixville, PA 19460
Phone 610-983-3980
Fax 610-983-3406

Patient Name: _____**D.O.B**: _____**Sex**: _____
Birthplace (state and country): _____**Last 4 Digits of SSN**: _____
How would you like to be addressed: _____**Reason for today's visit**: _____
Email Address: _____

Please select from the list below any medical conditions you currently have or have had in the past.
(Please circle ALL that apply): NONE N/A

Anxiety	Coronary Artery Disease	Hyperthyroidism
Arthritis	Depression	Hypothyroidism
Asthma	Diabetes	Leukemia
Afib/Irregular Heartbeat	End Stage Renal Disease	Lung Cancer
Bone Marrow Transplant	GERD/Esophageal Reflux	Lymphoma
Breast Cancer	Hepatitis	Prostate Cancer
Crohn's Disease	Hypertension	Radiation Treatment
Colon Cancer	HIV/AIDS	Seizures/Stroke
COPD/Emphysema	High Cholesterol	Ulcerative Colitis

Please list any other significant past medical history. (If none, please circle): NONE N/A
_____
Please list all past surgical history. (If none, please circle): NONE N/A
_____
_____

SKIN HISTORY DISEASE (Circle all that apply). NONE N/A OTHER

Acne	Melanoma	_____
Basal Cell Skin Cancer	Poison Ivy	
Blistering Sun Burn	Precancerous Moles	_____
Dry Skin	Psoriasis	
Eczema	Rosacea	_____
Flaking/Itchy Scalp	Squamous Cell Skin Cancer	
Hay Fever/Allergies	Warts	_____

Do you wear sunscreen? YES NO SPF: _____

Do you use or have you used a tanning bed? YES NO How frequently? _____

Do you have a family history of skin cancer? YES NO If yes, please list family members and types of skin cancer

_____
_____

PRESCRIPTION MEDICATIONS (if none, please circle): **NONE**

NAME OF MEDICATION	DOSAGE	FREQUENCY

ALLERGIES: Please list all drug allergies and reactions**. (If none, please circle): NKDA**

_____

_____

Do you drink alcohol? (Circle one): None Less than 1 drink per day More than 1 drink per day

Do you smoke? (Circle one): Current Smoker Former Smoker Never smoked

OCCUPATION: _____

Are you currently pregnant or planning pregnancy ? YES NO N/A

PRIMARY CARE PHYSICIAN

Name: _____ City: _____ Phone #:_____

PHARMACY (Local or mail order)

Pharmacy name: _____ City: _____ Pharmacy #:_____

PHONE MESSAGE CONSENT FORM

Notice of Privacy- Patient Acknowledgement

From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak to us directly, we would like to leave a message whenever possible. To assist us in protecting your privacy, please complete the following:

May we leave a detailed voice mail regarding lab results and/or biopsy results?

(Please circle) **YES** **NO**

May our billing department leave a message regarding your account?

(Please circle) **YES** **NO**

Please list the best phone numbers for us to contact you

Primary Phone Number _____ (Cell/ Home/ Work)

Alternative Phone Number _____(Cell/ Home/Work)

May we speak to someone else regarding your medical care? YES NO

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing below, I acknowledge that I have been provided the Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of me health information, and I was given an opportunity to read the notice. I understand I may revoke this consent at any time.

Signature: _____ Date: _____

Relationship to patient (if applicable): _____

Do you have a power of attorney (POA) ? (Please circle) YES NO

If yes, Name: _____ Relationship: _____

Phone number: _____

FINANCIAL POLICY

We at Phoenixville Valley Forge Dermatology and Associates, PC are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about this financial policy.

You agree to allow Phoenixville Valley Forge Dermatology Associates the right to service your account or collect monies you may owe. Our agents may contact you by telephone at any telephone number associated with your account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

COLLECTION POLICY AND AGENGY FEES

After services have been rendered and your insurance carrier has processed your claim, if there are any balances due you will have the option to pay in full or set up a payment plan. If arrangements have not been made to pay your outstanding balance after the third mailed statement, we will submit your account to our collection agency. Additionally, PVFDA will charge a $25.00 Reactivation Fee. This fee will be charged prior to future scheduling.

Agreement To Pay: If my account were to go to collections, I, the undersigned accept the fee charged (25% of the balance due) as a legal and lawful debt and agree to pay said fee.

I/We have read this disclosure and policies and agree with the above.

_____ _____

Responsible Party Signature Date

_____

Date of Birth

PHOENIXVILLE/VALLEY FORGE DERMATOLOGY ASSOCIATES

CANCELLATIONS / NO SHOWS FOR ALL MEDICAL AND SURGICAL APPOINTMENTS

We understand that circumstances may arise, but we ask that you cancel or reschedule at least 24 hours in advance. Cancellations made with less than 24 hours' notice, or missed appointments, will be charged with a $35 fee, which is not covered by insurance. Payment of this fee will be required prior to your next office visit

Print Patient Name

Date of Birth

Signature

Date of Birth