Verified information entered via portal
Staff initials: ______ Date: __________

(Please print legibly, and complete all fields)

Patient Legal Name____
Last First Middle

Address____
Street & Apartment # City State Zip

Home Phone (__________) __________________**Cell** (________) __________________**Work** (________) __________________

Email ______________________________________ By checking the preferences below, you consent to receiving communication regarding appointment & care reminders, (medical information & test results) and practice communication (announcements, newsletters, specials & events). We will never share or sell your email address for any purpose not related to your healthcare treatment. At any point, you may unsubscribe or opt-out of one or both types of communication.

Communication Preferences: Check ONLY one box for each type of communication

Appointment & Care Reminders (Check ONLY one): ☐ Call Home ☐ Call Cell ☐ Text ☐ Email

Medical Information or Test Results (Check ONLY one): ☐ Call Home ☐ Call Cell ☐ Call Work

Date of Birth ________________________ **Age** _________ **SS#** _________________ **Gender**_________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er

Ethnicity (Please check): ☐ Hispanic ☐ Non-Hispanic **Preferred language**_______________________________

Race: (Please check) ☐ African American ☐ Caucasian ☐ Asian ☐ American Indian ☐ Alaska Native

☐ Native Hawaiian ☐ Pacific Islander ☐ Mixed Race ☐ Other

Patient's Employer ____

Emergency Contact (Name) ______________________________________ **Relationship** ______________________________

Emergency Contact: Home/Cell Phone ___________________________**Work Phone** ______________________________

Primary Care Physician (First AND Last Name) ____

How did you hear about Farmington Valley Dermatology & Surgery? (Please check)

☐ Established Patient ☐ Physician ☐ Friend/Family ☐ Google ☐ Other ______________________

☐ Facebook ☐ Instagram ☐ Insurance Company ☐ Digital Ad/Email

Primary Health Insurance Company ____
Name on insurance card ______________________________________
Policy/ID # ______________________________________ **Group/ Plan #** ______________________________________
Policy Holder Name: ______________________________________ **Policy Holder DOB:** ______________________

Secondary Health Insurance Company ____
Name on insurance card ______________________________________
Policy/ID # ______________________________________ **Group/ Plan #** ______________________________________
Policy Holder Name: ______________________________________ **Policy Holder DOB:** ______________________

I understand that office visit charges are payable on the day the service is rendered. I authorize Farmington Valley Dermatology & Surgery to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Farmington Valley Dermatology & Surgery and myself. By entering your name below, it represents your signature attesting to your understanding of the information on the form and that the information entered is complete and accurate.

Printed Name/Signature ____**Date** ___________________________

FARMINGTON VALLEY DERMATOLOGY & SURGERY
Skin care for all generations

Verified information entered via portal
Staff initials: ______ Date: _________

History and Intake Form

Patient Legal Name: ________________________ Date of Birth: ____________ Date: ____________

Primary Care Physician: (name, location) ________________________________

Preferred Pharmacy: (name, city) ________________________________

REASON FOR VISIT:________________________________

Past Medical History: (check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Stroke
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Chemotherapy treatment
- ☐ Other:
- ☐ Depression
- ☐ Diabetes
- ☐ End-stage Renal Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Immunosuppression
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Bone Marrow Transplant
- ☐ Seizures
- ☐ Valve Replacement
- ☐ **NONE**

Past Surgical History: (check all that apply)

- ☐ Breast Implants
- ☐ Breast Reduction
- ☐ Coronary Artery Bypass
- ☐ Kidney Transplant
- ☐ Colostomy
- ☐ Other:
- ☐ Tubal Ligation
- ☐ Heart Valve replacement
- ☐ Hysterectomy
- ☐ Lumpectomy (R, L, bilateral)
- ☐ Mastectomy (R, L, bilateral)
- ☐ Ovaries removed (cyst, ovarine, cancer)
- ☐ Pancreas removed
- ☐ Prostate removed (cancer)
- ☐ Spleen removed
- ☐ Kidney removed.
- ☐ Hip Replacement (R, L, bilateral)
- ☐ Knee replacement (R, L, bilateral)
- ☐ Heart Transplant
- ☐ Liver Transplant
- ☐ **NONE**

Skin Disease History: (check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis (pre-cancers)
- ☐ Basal Cell Skin Cancer
- ☐ Other:
- ☐ Dysplastic (atypical) mole
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hay fever/Allergies
- ☐ Malignant Melanoma
- ☐ Squamous Cell Skin Cancer
- ☐ Rosacea
- ☐ **NONE**

Do you have **family** history of Malignant Melanoma? ☐Yes ☐ No ☐ Unknown If **yes**, which relative: ____________

Medications: Please enter medications (including over-the-counter medications and supplements) OR provide your own list

Medication	Dosage		

Drug Allergies and Reaction to drug:: ________________________________☐ No Known Drug Allergies

Smoking Habit ☐ Never Smoker ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Smoker (not daily) ☐

Alcohol Use ☐ None ☐ Less than 1 drink a day ☐ 1-2 drinks a day ☐ 3 or more drinks a day

How many times in the past year have you had 5 or more drinks in a day if male under age 65, OR 4 or more drinks in a day if female any age or male age 65 and over? (enter 0 to 365 days) _________

Do you use tanning beds? ☐ Yes ☐No **Do you use sunscreen** ☐ Yes ☐No If yes what **SPF**? ______________

Did you receive your Flu vaccine this flu season (October-March)? ☐ Yes ☐No If no why? __________

Have you ever received a pneumonia vaccine (Age 65+ years)? ☐ Yes ☐No If no why? __________

Do you have an Advanced Care Plan? ☐ Yes ☐No ***Do you have a Living Will for medical treatment?*** ☐ Yes ☐No

Do you have a healthcare proxy (surrogate decision maker)? ☐ Yes ☐No

If "Yes", please enter: proxy/decision maker name: ____________________ ***phone below: phone:*** ______________

FARMINGTON VALLEY DERMATOLOGY & SURGERY
Skin care for all generations

Verified information entered via portal
Staff initials: _____ Date: _________

History and Intake Form

Name: ___________________________ Date of Birth:_________________________

Review of Systems:

Are you currently experiencing any of the following?

(please check yes or no for the following).

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
Chest pain		
Shortness of breath		
Rash		
Changing mole		
Dry skin/lips		
Nosebleeds		
Unintentional weight loss		
Change in appetite		
Headaches		
Ringing in the ears		
Blurry vision		
Abdominal pain		
Bloody stool		
Joint aches		
Anxiety		
Depression		
Thoughts of hurting yourself or others		
Fever/chills		
Night sweats		
Sore throat		
Cough		
Muscle weakness		
Nausea or vomiting		
Irregular periods		
Seizures		
Dizziness		
Heat or cold intolerance		
Loss of taste/smell		
Body/muscle aches		
Bipolar Disorder		
Hidradenitis Suppurativa		

(FOR PATIENTS 18 YEARS AND YOUNGER)

____

Height: ___________________ Weight: _________________

Alerts:

Are any of the following true for current health?

(please check yes or no for the following)

Alert	Yes	No
Pregnancy or planning a pregnancy		
Defibrillator		
Pacemaker		
Blood thinners		
Artificial heart valve		
Premedication prior to procedures		
Artificial joints in past two years		
Taken isotretinoin in the last year		
Immunosuppression		
HIV		
Hepatitis B or C		
History of Cancer		
History of Melanoma		
Allergy to lidocaine		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Rapid heartbeat with epinephrine		
Yeast infections with antibiotics		
Gastrointestinal upset with antibiotics		
Breastfeeding		

FARMINGTON VALLEY DERMATOLOGY & SURGERY
Skin care for all generations

Consent and Policies

FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any medical services being rendered.

1. FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY.
2. WE ACCEPT CASH, CHECKS, VISA, AMERICAN EXPRESS, MASTERCARD AND DISCOVER.
3. WE OFFER AN EXTENDED PAYMENT PLAN FOR SURGERIES WITH PRIOR APPROVAL FROM OUR OFFICE MANAGER.

Regarding Insurance:

We may or may not accept assignment of your insurance benefits. If assignment is taken, you will still be responsible for any deductibles or copayments at the time services are rendered. Your insurance policy is a contract between you and your company; we are not a party to that contract unless we also have a contract with your company. If your insurance company has not paid on your claim within 45 days, you will automatically be responsible for the balance. If your balance is not paid within 60 days, your account will be turned over to a collection agency and a fee of 15% of the outstanding balance will apply.

Please be aware that some, and perhaps all, of the services provided may be deemed non-covered services or not medically necessary under Medicare and/or other medical insurance programs and you are responsible for payment.

Regarding insurance plans where we are a participating provider, all copayments and deductibles are due at the time services are rendered. In the event your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraphs.

Usual and Customary Rates:

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult parent accompanying the minor is responsible for payment of the minor's patient's account regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

I authorize Farmington Valley Dermatology & Surgery to release my information, including the diagnosis and records of any treatment(s) or examination(s) rendered to me or my child, to my insurance company(s) necessary to process claims. I also authorize and request my insurance company(s) to make payment of any medical benefits directly to the physician or Farmington Valley Dermatology & Surgery.

PATIENT RIGHTS

I have been given the opportunity to review and understand my patient rights. I may request a copy at any time.

NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review and understand the notice of privacy practices and may request a copy at any time.

USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS:

I consent for FVD to use and disclose my information for treatment, payment, or healthcare operations as stated in the notice of privacy practices. I may revoke this consent at any time by submitting a revocation in writing to Farmington Valley Dermatology & Surgery.

PHONE CONSENT: I authorize the physicians and staff of Farmington Valley Dermatology & Surgery to:

(Please indicate your preference, and list the preferred phone number)

- Leave a message on my answering machine on Home/Cell Phone? ☐ **NO** ☐ **YES** **Tel #**____________________
- Leave a message at my place of employment? ☐ **NO** ☐ **YES** **Tel #** ____________________
- Discuss my medical condition with a member of my household ☐ **NO** ☐ **YES** **Tel #** ____________________
  - **If yes, whom** ______________________________ **Relationship** ______________________________

CONSENT FOR MINOR TO PRESENT THEMSELVES FOR TREATMENT

Farmington Valley Dermatology & Surgery offers the privilege of seeing minors without a parent or legal guardian present for the visit. The following written consent must be signed prior to the minor being seen. **An accompanying adult who is not a parent or legal guardian cannot provide consent.** I, ____________________, as parent or legal guardian, give my consent for ____________________**to be seen without a parent or guardian** for evaluation and treatment. If is a procedure is proposed by the provider, I must be available to provide verbal consent over the phone to be witnessed by the medical assistant or the procedure will be deferred. I acknowledge that the provider may insist a parent or guardian be present for decisions about treatment or procedures. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

All patients must complete this section: I have read, understand and agree to these policies.

By entering your name below it represents your signature attesting to your understanding of the information on the form and that the information entered is complete and accurate.

SIGNATURES

____ ________________________

Printed Name/Signature of Patient (If patient is under 18, a parent or guardian must sign.) Name of Patient

________________________ ________________________ ____________

Relationship to minor patient (if applicable) Name of minor patient (if applicable Date