warrenton
Dermatology & Skin Therapy Center

Dear Patient:

Welcome and thank you for choosing our practice.

Please bring the following with you to your appointment:

- Your completed forms, along with your current insurance card, photo identification (such as a current driver's license or state issued form of identification) and any applicable co-payment or co-insurance, which may be paid by cash, check or credit card.
- Please arrive 20 minutes prior to your appointment time *if you do not have your completed forms with you.*
- If your insurance carrier requires a written referral, please be sure to have the original signed form or fax from your Primary Care Physician before you are seen. If you are not sure whether or not you need a written referral, please contact your insurance company.
- If the patient is a minor, we do require a parent to attend the first visit to obtain accurate medical history.
- If you are at least 10 minutes late for your appointment, we will reschedule your appointment.
- Should you be unable to keep your appointment for any reason, we require a 24 hour notice. Failure to notify us of your cancellation for a medical appointment may result in a $50.00 charge. Failure to notify us of your cancellation for a surgery or cosmetic appointment may result in a $100.00 charge. Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations and "no-shows." These fees are not reimbursable by your insurance company.

If you have any questions, feel free to call our office. We look forward to seeing you.

Driving Directions:

From N. VA - Take I-66 to the Route 29 Gainesville exit and go south onto Route 29 to Warrenton. Take the Business Route 29 / Route 211 exit (1st Warrenton exit). At the first stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

From Fredericksburg - You can take Route 3 or Route 17 North until you get to Route 29 and go north to Warrenton. Take the Business Route 29 / Rt. 211 exit (3rd Warrenton exit). At the first stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

From Culpeper - Take Route 29 North to Warrenton. Take the Business Route 29 / Route 211 exit (3rd Warrenton exit). At the first stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

From Middleburg/Winchester - Take Route 17 south to Warrenton. Take the Route 17 spur (bear right after Ben and Mary's Restaurant to the exit for Business Route 29 / Route 211. At the stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

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PATIENT REGISTRATION FORM

Please Print and Complete the Following Information

Demographic Information:

Date: _____

Patient's First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Sex: M___ F___

Mailing Address: _____
(Street or P.O. Box) (City) (State) (Zip Code)

Marital Status: Single___ Married___ Partnered___ Divorced___ Widowed___

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Referring Physician: _____ **Phone**: _____

Primary Care Physician: _____ **Phone**: _____

How did you hear about us? ☐ Physician _____ ☐ Friend ☐ Internet ☐ Facebook ☐ Print Ad

For Minors Only: Please provide the following information for the Minor's Responsible Party

Name: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information: All patients must present their insurance card(s) at the time of each visit

Primary Insurance Carrier: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient: Self___ Spouse___ Parent___ Other___

Identification Number: _____ Group Number: _____

Secondary Insurance Carrier: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient: Self___ Spouse___ Parent___ Other___

Identification Number: _____ Group Number: _____

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PATIENT ACKNOWLEDGEMENTS OF OFFICE POLICIES

Insurance Information – Co-payments and Deductibles
Warrenton Dermatology & Skin therapy Center will file your claim with your insurance if we participate with your insurance plan. Otherwise, payment is required in full for all services at the time they are rendered. Should any services not be covered by your insurance, you agree to accept financial responsibility for said services. All applicable co-payments and deductibles are to be paid in full and collected at the time of your visit. Returned checks are subject to a $25.00 administrative fee. Your signature below signifies your understanding and willingness to comply with this policy.

Referral Information
If a referral is required by your health insurance plan, it is your responsibility to obtain the referral from your Primary Care Physician and assure it is available to be presented at the time of your visit. Additionally, it is your responsibility to keep track of the number of visits you have used on your referral, the expiration date of your referral and obtain new ones as needed. Should you fail to have a valid referral for your visit, insurance regulations require that you sign a financial waiver. Your signature below signifies your understanding and willingness to comply with this policy.

Insurance Cards
All patients will be required to provide valid insurance card(s), or a temporary print out at the time of their visit. Should you be unable to produce this documentation, insurance regulations require that you sign a financial waiver. Your signature below signifies your understanding and willingness to comply with this policy and that you are responsible for notifying our office of any changes to your insurance or contact information.

Cancellation Policy
We require a 24 hour cancellation notice for all appointments. Failure to notify us of your cancellation for a medical appointment may result in a $50.00 charge. Failure to notify us of your cancellation for a surgery or cosmetic appointment may result in a $100.00 charge. Regretfully, we have been forced to institute this policy due to a large volume of last minute cancellations and "no-shows." These fees are not reimbursable by your insurance company.

Virginia Law (Section 32.1-45.1 et. Seq.)
I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the healthcare provider, it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia Law (Section 32.1 – 45.1 et seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed healthcare provider. I also understand that health providers are deemed to consent to tests and the release of results to me, should I be similarly exposed.

Informed Consent for In-Office Procedures

I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance. I authorize my physician to perform such procedures (shave biopsies, punch biopsies, and cryotherapy) which in his/her judgement are incidentally necessary or appropriate to carry out my diagnosis/treatment. I understand that the provider may ask other providers and /or clinical staff to participate in my care. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of my procedure.

_____ _____
Patient Signature (Parent or Guardian if patient is a minor) Date

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Name: _____ **Date of Birth:** _____ **Date:**_____

Reason for today's visit: _____

List your current medications:

Medication Name	Dosage/Frequency Taken	Medication Name	Dosage/Frequency Taken

Medication allergies: _____

Preferred pharmacy: _____ Street & Town address: _____

SKIN HISTORY:

- Do you: ☐ always burn ☐ burn first then tan ☐ never burn
- Have you ever had a blistering sunburn (even as a child)? ☐ Yes ☐ No
- Have you ever used a tanning bed? ☐ Yes ☐ No
  - If yes, how often: ☐ sporadically ☐ regularly ____ times a week for ____ months/years
  - If yes, are you still using them? ☐ Yes ☐ No
- Do you develop keloids or thick scars after surgery? ☐ Yes ☐ No
- Are you prone to herpes outbreaks around the mouth (aka. cold sores/fever blisters)? ☐ Yes ☐ No
- Do you get faint or vasovagal with procedures (blood work/lab tests, skin biopsies)? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms?

☐ Fevers/Chills
☐ Nightsweats
☐ Unusual Weight Changes
☐ Loss of Appetite
☐ Swollen Glands
☐ Arthritis/Joint Pains
☐ Difficulties with Hot/Cold Temp.
☐ Muscle Weakness
☐ Sun Sensitivity
☐ Fatigue
☐ Flushing
☐ Excessive Sweating
☐ New Onset Headaches
☐ Hair Loss/Hair Growth
☐ Itching
☐ Mouth or Throat Sores
☐ Genital Sores
☐ Painful Urination
☐ Nausea/Vomiting/Diarrhea
☐ Visual Symptoms
☐ _____

SCREENING HISTORY: Place a date for your last test, if applicable.

Dental Exam _____ Pelvic Exam _____ Prostate Exam/PSA _____

Eye Exam _____ Mammogram _____ Colonoscopy _____

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Name: _____ **Date of Birth:** _____

MEDICAL HISTORY: Do you have now, or have you had in the past, any of the following diseases or conditions?

☐ Acne
☐ Asthma
☐ Atypical Moles
☐ Seasonal Allergies
☐ Eczema
☐ Psoriasis
☐ Skin Cancer:
Type _____
☐ Lupus or Other Connective Tissue Disease
☐ Polycystic Ovarian Syndrome
☐ Sexually Transmitted Disease:
Type _____
☐ Other: _____

☐ Anemia
☐ Bladder or Prostate Problems
☐ Bleeding Disorder
☐ Blood Clots
☐ Cancer (*not skin*):
Type _____
☐ Cataracts/Glaucoma
☐ COPD
☐ Diabetes
☐ Endocarditis
☐ Heart Disease/Heart Attack
☐ Heart Murmur
☐ Irregular Heartbeat
☐ Hepatitis

☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Problems/Dialysis
☐ Liver Problems
☐ Mitral Valve Prolapse
☐ Nerve Problems
☐ Psychiatric Problems
☐ Seizure Disorder
☐ Stroke
☐ Transplant:
Type _____
☐ Tuberculosis/ Lung Problems
☐ Thyroid Disease

Do you have or require any of the following?

☐ Artificial Heart Valves
☐ Pacemaker or Defibrillator
☐ Artificial joints or other metal implants
Date of Implant _____

Do you require antibiotics before procedures or dental cleanings? ☐ Yes ☐ No
Do you take aspirin, Coumadin or Plavix? ☐ Yes ☐ No
Are you on immunosuppressants? ☐ Yes ☐ No

FAMILY HISTORY: List a member of the family with any of the following (grandparent, parent, sibling, child)

☐ Scarring Acne or Accutane use _____
☐ Seasonal Allergies _____
☐ Asthma _____
☐ Eczema _____
☐ Psoriasis _____
☐ Melanoma _____

☐ Basal Cell Cancer _____
☐ Squamous Cell Cancer _____
☐ Other Skin Cancer _____
☐ Thyroid Disease _____
☐ Lupus _____
☐ Other Autoimmune Disease _____

SOCIAL HISTORY:

Do you or have you smoked (cigarettes/cigars/pipes)? ☐ Yes ☐ No If yes, how many packs per day now? _____
Do you or have you chewed tobacco? ☐ Yes ☐ No Have you quit chewing tobacco? _____
Do you or have you used other drugs? ☐ Yes ☐ No If yes, what kinds? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

FOR FEMALES ONLY:

☐ Irregular periods
☐ Hair growth in unwanted/unusual areas
☐ Breast Feeding
☐ Pregnant

☐ Trying to conceive
☐ Difficulty conceiving children
☐ Taking oral contraceptives
☐ Forms of birth control: _____
_____

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HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your right under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations
2. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice
3. The Practice reserves the right to change the Notice of Privacy Policies
4. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease
6. The practice may condition treatment upon the execution of this Consent.

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Warrenton Dermatology & Skin Therapy Center from discussing appointment, medication, test results, or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for them. **If you would like to permit someone to discuss your medical condition, confirm appointments, or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information.**

Name of Individual (Please Print)	Relationship to Patient

I would prefer to be reached by:

Home Phone_____ Cell phone_____ Home Voicemail_____ Patient Portal_____

May we leave a message? Yes_____ No_____

Patient statement: I am aware of my HIPAA and Patient Rights (please request a copy at the front desk)

_____ _____

Patient signature (Parent or Guardian if patient is a minor) Date

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Skin Therapy Center Questionnaire

Patient Name: _____ Date of Birth: _____

Preferred Phone Number: _____

Please check any areas you would like to discuss, or for which you would like more information:

☐ Acne	☐ Fraxel® Skin Resurfacing	☐ Lip Augmentation
☐ Botox®	☐ Freckles	☐ Lines Around the Mouth
☐ Brown Spots	☐ Frown Lines	☐ Microdermabrasion
☐ Chemical Peels	☐ IPL Laser Facials	☐ Rosacea
☐ Facial Fillers	☐ Juvederm®	☐ Skin Care Regimen
☐ Excessive Sweating	☐ Kybella®	☐ Skin Care Products
☐ Facials	☐ Large Pores	☐ Skin Tags
☐ Facial Redness	☐ Laser Hair Reduction	☐ Sun Damage
☐ Facial Veins	☐ Latisse®	☐ Voluma®

Other _____

Have you had any cosmetic surgery or procedures in the past 5 years? ☐ Yes ☐ No

To receive our monthly e-newsletter, containing informative articles and special offers,

Please provide your email address: _____

Like us on Facebook - for information on treatment options, events & special offers

Follow Us on Twitter

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