FAMILY DERMATOLOGY of ALBEMARLE

Brett D. Krasner, M.D.
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Charlottesville, VA 22911
(434) 964-9500
www.drkrasner.com

Name:_____Date:_____ *DO YOU REQUIRE PREMEDICATION BEFORE*

Today's visit is for:_____ *SURGICAL/DENTAL PROCEDURES*? YES/NO

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

How did you learn about us?

: Primary Care Physician (PCP)_____
: Another Dermatologist _____
: Family/Friend/Co-Worker_____
: The Embarq Yellow Pages
: Other (Specify) _____

MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL PHYSICIAN DIAGNOSED MEDICAL CONDITIONS

- ❑ ***Skin Cancer:***
  - o Melanoma; Date:_____ Location_____
  - o Squamous Cell Carcinoma
  - o Basal Cell Carcinoma
  - o Actinic Keratosis (pre-skin cancer)
  - o Other:_____
- ❑ ***Dermatological Disease:***
  - o Herpes/Cold sores
  - o Psoriasis
  - o Eczema
  - o Acne / Rosacea
  - o Blistering Disorder:_____
  - o Healing problems; slow, keloid, bruising
  - o Other:_____
- ❑ ***Immunological Disease:***
  - o Immune Deficiency
  - o HIV / AIDS
  - o Lupus or Scleroderma
- ❑ ***Hematology / Oncology:***
  - o Cancer; type:_____
  - o Bleeding Problems
- ❑ ***Rheumatological Disease:***
  - o Osteoarthritis
  - o Rheumatoid Arthritis
  - o Gout
- ❑ ***Psychological / Emotional Disease:***
  - o Depression
  - o Obsessive – Compulsive
- ❑ ***Gastrointestinal Disease***:
  - o Crohn's Disease, Ulcerative Colitis
  - o Esophageal Reflux
  - o Peptic ulcer
  - o Esophagitis
- ❑ ***Cardiovascular Disease:***
  - o High Blood Pressure
  - o Heart Problems: _____
  - o Heart Attack; Date:_____
  - o Pacemaker / AICD
  - o Irregular heartbeat
  - o High Cholesterol
- ❑ ***Endocrine Disease:***
  - o Diabetes
  - o Hyperthyroid / Hypothyroid
- ❑ ***Neurological Disease:***
  - o Stroke / Aneurysm
  - o Seizure / Epilepsy
  - o Alzheimer's
  - o Fainting
- ❑ ***Liver Disease:***
  - o Hepatitis; type:_____
  - o Jaundice
- ❑ ***Lung Disease:***
  - o Asthma
  - o COPD
  - o Tuberculosis
- ❑ ***Kidney Disease:***
  - o Poorly functioning kidneys
  - o Dialysis; type_____
- ❑ ***For Female Patients:***
  - o Are you pregnant / Planning Pregnancy
  - o Polycystic ovarian disease
- ❑ ***Other / Not Listed:***
  - o _____
  - o _____
  - o _____
  - o _____

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:

SURGERIES			
TYPE OF SURGERY	**SURGEON**	**HOSPITAL**	**DATE**

HOSPITALIZATIONS (DO NOT INCLUDE SURGERIES LISTED ABOVE)			
REASON	**DOCTOR**	**HOSPITAL**	**DATE**

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)	
Conditions/Problems	***Family Members affected and exact nature of problems***
❑ Melanoma	
❑ Non-Melanoma Skin Cancer	
❑ Blistering Disorder	
❑ Auto-Immune Disorder	
❑ Psoriasis	

SOCIAL HISTORY / HABITS

❑ Occupation_____ ❑ Retired
❑ Smoker: _____ packs/day ❑ Non-smoker ❑ Quit smoking in _____
❑ Smokeless Tobacco:_____
❑ Alcohol use: ❑ Yes (drinks/week:_____) ❑ No
❑ Recreational Drug use: ❑ No ❑ Yes _____
❑ Sunscreen use: ❑ Regularly ❑ Rarely ❑ Never
❑ I have traveled outside the United States in the past three months:_____

TANNING / SUN EXPOSURE

Do you / Have you had
- ❑ Always burn, never tan
- ❑ Usually burn, tan w/ difficulty
- ❑ Sometimes burn, usually tan
- ❑ Rarely burn, tan easily

❑ At least 1 blistering sunburn
❑ Utilize a tanning bed

REVIEW OF SYSTEMS: Please mark the symptoms you've been having recently.

GENERAL
- ❑ weight gain / loss
- ❑ loss of appetite
- ❑ fever / chills
- ❑ weakness
- ❑ night sweats

SKIN
- ❑ rash
- ❑ lumps
- ❑ dry/sensitive skin
- ❑ hives
- ❑ suspicious moles
- ❑ suspicious lesions
- ❑ jaundice
- ❑ acne
- ❑ itching
- ❑ hair loss

EAR/NOSE/THROAT
- ❑ congestion
- ❑ nosebleed
- ❑ change in voice
- ❑ sore throat
- ❑ difficulty swallowing

ALLERGY
- ❑ runny nose
- ❑ scratchy throat
- ❑ itchy eyes
- ❑ sinus congestion
- ❑ sneezing

CARDIOLOGY
- ❑ chest pain
- ❑ palpitations
- ❑ leg swelling

MUSCULOSKELETAL
- ❑ joint stiffness
- ❑ leg cramps
- ❑ joint pain
- ❑ joint swelling
- ❑ back pain
- ❑ neck pain
- ❑ muscle aches

RESPIRATORY
- ❑ shortness of breath
- ❑ chest tightness
- ❑ cough
- ❑ wheezing
- ❑ congestion

PSYCHOLOGY
- ❑ depression
- ❑ high stress level
- ❑ suicidal thinking
- ❑ eating disorder
- ❑ mental or physical abuse
- ❑ mood swings
- ❑ obsessive - compulsive tendencies

ENDOCRINE
- ❑ excessive sweating
- ❑ excessive thirst
- ❑ excessive urination
- ❑ heat intolerance
- ❑ cold intolerance

BLOOD/LYMPH
- ❑ swollen glands
- ❑ fatigue
- ❑ varicose veins
- ❑ easy bruising

_____
Patient Signature Date

EYES
- ❑ decreased vision
- ❑ eye irritation
- ❑ eye drainage
- ❑ blurry vision

NEUROLOGY
- ❑ headache
- ❑ tingling/numbness
- ❑ seizures
- ❑ dizziness

GASTROENTEROLOGY
- ❑ nausea
- ❑ vomiting
- ❑ heartburn
- ❑ abdominal pain
- ❑ change in bowel habits

UROLOGY
- ❑ difficulty urinating
- ❑ blood in urine
- ❑ leaking urine

_____
Physician Signature Date

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As a new patient, please complete these forms and bring them with you.
Please arrive 15 minutes prior to this scheduled time for your first appointment.

Preferred Pharmacy
Name:
Address:
City, State, Zip:
Phone Number:
Fax:

Patient Name

Address

City, State, Zip

Home Phone ( ) Cell Phone ( ) Work Phone ( )

Date of Birth SSN Marital Status: S M D W Other

Gender: Male____ Female____ Race:

Employer

May we leave a message on your home answering machine and/or cell phone voice mail? Yes No
May we leave a message on your work voice mail? Yes No
May we leave a message with any member of your household? Yes No
If yes, whom:_____ Relationship:_____
May we discuss your medical condition with any member of your household? Yes No
If yes, whom:_____ Relationship:_____
May we contact you by e-mail? Yes No Address_____

Emergency Contact:

Name Relationship

Phone ( )

Insurance Information (The Receptionist will copy your insurance card.)

IF OTHER THAN PATIENT, PLEASE COMPLETE THE FOLLOWING:

Name of Primary Insurance

Subscriber's Name Relationship to Patient:
Self Spouse Parent

Address

City, State, Zip

Phone ( ) Date of Birth SSN

Name of Secondary Insurance

Subscriber's Name Relationship to Patient:
Self Spouse Parent

Address

City, State, Zip

Phone ( ) Date of Birth SSN

PLEASE NOTE THAT THERE WILL BE A CHARGE OF $25.00 FOR MISSED APPOINTMENTS.

Rev. 9/07

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Conditions of Registration and Financial Policy

Patient Name:_____Date of Birth:_____

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

- **BASIC POLICY** Payment is due in full at the time service is provided in our office.
- **FOR PATIENTS WITH MEDICARE** We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments.
- **FOR PATIENTS WITH INSURANCE** All co-payments and deductibles are due at the time of service. We will bill insurance carriers on your behalf if we have a current contract with the carrier. We will submit a courtesy claim on your behalf to insurance carriers with which we do not participate. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you.
- **NONCOVERED SERVICES** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.
- **MISSED APPOINTMENTS** In fairness to other patients and the doctor, we require at least 24 hours notice to cancel an appointment. You may be charged $25.00 for each appointment that was missed or not canceled with 24 hour notice. Missing more than two appointments without providing 24 hours notice is grounds for discharge from the practice.
- **RETURNED CHECKS** There will be a fee of $25.00 charged by this office for each check returned to us by your bank.
- **COLLECTION AGENCY COSTS** In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees or court costs.

MEDICARE PATIENTS: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits be made to Family Dermatology of Albemarle, PLC for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-insurance, and any non-covered services.

Signature:_____Date:_____

ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Family Dermatology of Albemarle, PLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorized said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

Signature:_____Date:_____

I have read, understood, and agree to be bound by the terms of this financial policy.

Signature:_____Date:_____

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Deemed Consent for Designated Blood Borne Pathogens

Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any healthcare worker associated with or working for Family Dermatology of Albemarle PLC is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit Human Immunodeficiency Virus (Aids) or Hepatitis B and C, Family Dermatology of Albemarle PLC will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for HIV and Hepatitis B and C for the safety of all concerned. This policy protects you as a patient, should you be exposed.

Consent to Medical Care

I voluntarily consent to medical care at Family Dermatology of Albemarle which may include examinations, tests, photographs, and treatments by Dr. Krasner and staff. No promises have been made to me as to the results of treatment or examinations.

Parental Consent for Child Under 18 Years of Age

I am present with my child_____today and I give my consent to Dr. Krasner to see and treat my child as indicated. I give my permission for continued follow-up care which may include changes to the treatment plan in my absence. (No invasive procedures will be performed without direct notification to the parent.)

Consent to the Use and Disclosure of Health Information for Treatment, payment or Healthcare Operations

I acknowledge that I have been offered and/or received a copy of Family Dermatology of Albemarle's Notice of Privacy Practices.

Signed:_____Date:_____