LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD.

DAVID B. VASILY, M.D.
MICHELLE D. RAMSBERGER, PA-C
LIANNE MCGINN-BUNN, PA-C
JENNA KUNSMAN, PA-C
VINCENT NOCELLA, PA-C

190 BRODHEAD ROAD
SUITE 205
BETHLEHEM, PA 18017
(610) 866-2010
FAX (610) 866-4359

Dear Patient,

Welcome to our practice. Although the following forms may seem cumbersome, the information provided enables us to better understand your skin condition and possible relationship to your general medical health.

Simply do the best you can with these forms. Our assistants are available to assist you with specific questions when you are in the exam room.

Your appointment is very important to you and to us. During each day, we have a limited number of appointments available to accommodate all of our patients. If you are not able to keep your appointment, we require notice of at least 48 hours before your scheduled appointment. If notice of cancellation is not given at least 48 hours in advance of your scheduled appointment, you will be charged a fee of $200.00. The fee will be charged to your credit card you provided to reserve your appointment time. Payment of this fee is required before you are able to reschedule your appointment.

We are committed to providing a safe, respectful, and professional environment for our patients and staff. We expect all patients and visitors to treat our staff members with courtesy and respect. Verbal abuse, yelling, screaming, threatening or intimidating behavior, aggressive conduct, harassment, or other inappropriate behavior toward our staff will not be tolerated. If a patient engages in this type of behavior, the practice reserves the right to immediately terminate the encounter and dismiss the patient from the practice. In situations involving threatening or aggressive behavior, appropriate authorities may be contacted when necessary. We appreciate your cooperation in maintaining a safe and respectful environment for everyone.

Sincerely,

David B. Vasily, M.D.
Michelle Ramsberger, PA-C
Lianne McGinn-Bunn, PA-C
Jenna Kunsman, PA-C
Vincent Nocella, PA-C

By signing below, you acknowledge notice of our cancellation policy, the code of conduct policy, and agree to abide by its terms.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PATIENT SIGNATURE DATE

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Patient Demographic Information

Patient Name: _____
(Last, First, Middle)

Nickname: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Marital Status: _____ Preferred Language: _____ Employer: _____

Primary Care Physician: _____

Address: _____ Phone Number: _____

_____

How did you hear about us: (check one)

Patient Referral: _____ Provider referral: _____ Insurance referral: _____ Web search: _____

Social Media: _____ Event: _____ Direct Mail: _____ Magazine: _____ Other: _____

Responsible Party:

Name (Last, First): _____ DOB: _____

(if different than above or if patient is a minor)

Guarantor Name (Last, First): _____ *Relationship:* _____

DOB: _____ Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Insurance Information

Primary Insurance: _____ Policy Holder Name: _____ Policy Holder DOB: _____

Relationship to Patient Relationship to Patient: _____ Member ID #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder Name: _____ Policy Holder DOB: _____

Relationship to Patient Relationship to Patient: _____ Member ID #: _____ Group #: _____

Patient / Guarantor Signature: _____ **Date:** _____

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No Show Attestation Policy

Due to an increasingly prevalent problem of no-show follow-up and new patient visits to our office, we are forced to implement a no-show policy as outlined below. The effect of these no-show visits is that the medical costs, to our other compliant patients, are driven up and valuable time slots are taken away from patients who need appointments. We require new patient appointment time frames to be held with a credit card on file. Our practice reserves the right to charge your credit card in the event you do not show for your new patient appointment, your credit card on file will be charged the no show fee schedule listed below. If you no-show a new patient appointment you will not be rescheduled. If you are an established patient, and you do not show for a scheduled appointment you will be charged the no show fee accordingly, and depending on the number of times you do not show for an appointment, you will be dismissed from the practice. If you do not satisfy the no show fee your patient status will be affected in accordance to the financial policy agreement. Please keep in mind that we do not double book appointments and if you fail to cancel your appointment with more than forty-eight hours' notice, a patient that may need the appointment will not be seen.

In addition, if you are running late, please call our office prior to your arrival to verify whether or not you will be seen. Depending on how late you will be and the provider's schedule, your appointment may be rescheduled.

Description	Fee	Consequences
Now show fee for office visits	$120	Fee only for 1st and 2nd time
No show fee for procedure	Equivalent to your procedure fee	Fee only for 1st and 2nd time
New patient appointment	$200	Fee only for 1st appointment

I have read the above and completely understand the language and meaning of the attestation no-show policy given to me, and I have had a chance to ask questions about this policy to my provider or staff. I am willing to comply with Lehigh Valley Dermatology's no-show policy. I understand the terms above and realize that any violation of the no-show policy I will be charged the fees described above, and if occurrences continue may result in my discharge from the practice.

I have read the above no-show attestation policy and agree to the terms of the policy.

_____ _____

Patient printed name | Date of birth

_____ _____

Patient Signature | Date

_____ _____

Employee Signature | Date

LEHIGH VALLEY DERMATOLOGY ASSOCIATES

190 Brodhead Rd., Suite 205
Bethlehem, PA 18017

Financial Policy, Referral/Pre-Authorization Policy & Credit Card Authorization

We thank you for choosing Lehigh Valley Dermatology Associates. We ask all of our patients to read and agree to our financial policy. We are happy to answer any questions you may have before you sign this. Unfortunately, patients who refuse to sign this are not able to be seen and may be subject to our appointment cancellation policy and fee.

We understand that healthcare and health insurance are very expensive, and we want you to receive the benefits and services from your insurance to which you are entitled. However, your insurance is a contract between you and your insurance company (and sometimes your employer). We have no control over what your specific insurance plan will cover and what they will not cover. In fact, it is not uncommon for insurance companies to cover something one month, and then decide not to cover it the next month. This is particularly true of non-Massachusetts-based insurances.

It has become increasingly time-consuming for our office to argue with insurance companies on your behalf to get them to pay your claim. If we have to spend time doing that, it means that other patients who need medical attention from us may not receive it. That "other" patient who needs us could one day be you or a family member. Therefore, any disputes on insurance claims will be your responsibility to dispute. We will provide you with any necessary documentation to aid you in this process. If you have a coordination of benefits issue, you should have received a notification in the mail from your insurance company to call your insurance company to confirm your primary insurance information. If you do not do so your claims will be denied and you will become a self-pay patient in our office. The insurance company will not allow our practice to call on your behalf to verify your primary and secondary insurance plans. If you have an appointment and your coordination of benefits is not corrected, you will become a self-pay patient for the visit or your appointment will be rescheduled for a time when the coordination of benefits has been corrected. If you choose to become a self-pay patient, once you correct the coordination of benefits with your insurance company, we will submit the claim on your behalf (participating insurances only). If you are due a credit, one will be issued once we receive the explanation of benefits from your insurance company.

Your agreement with your insurance company is between you and your insurance company. If you do not agree with any out-of-pocket determinations, you must contact your insurance company on your own behalf to express your concerns with your insurance company's determination of coverage for the service(s) we provided. However, you will be required to pay the out-of-pocket expenses up front and submit a request to your insurance company for a refund to be paid directly to you. We will not hold payment obligations for an insurance dispute on your behalf. All co-pays, deductibles, co-insurances, self-pay or procedures not covered under insurance are due at the time of visit. If your insurance does not provide detailed information as to your exact out of pocket at the time of service, you will be responsible for any out of pocket your insurance deems is your responsibility after the claim is reviewed by your insurance provider. Given the trend of higher deductible plans, if you are in deductible, you will be given an estimate of out-of-pocket expense at the time of your visit; along with any co-pays, co-insurances, and account balances. If you are unable to satisfy any of the aforementioned, your appointment will be rescheduled for another time when you are able to satisfy your financial obligations.

LEHIGH VALLEY DERMATOLOGY ASSOCIATES

190 Brodhead Rd., Suite 205

Bethlehem, PA 18017

If you choose to pay by method of a credit card or bank card; your signature on the next page IS your authorization to process any credit card or bank card payments you present to us to satisfy your account balance. Your signature for a credit or bank card authorization does not obligate you to use a card as a method of payment. It merely gives us the option to process a card in the event you choose to use a card. We require a new patient appointment to be held with a credit card on file. In the event you do not show for your new patient appointment, your credit card will be charged a no-show fee according to our no-show cancellation policy. If the card you provide is not valid, we will contact you for a valid card. In the event we are not able to obtain a valid credit card, you will be dismissed from the practice. In addition, if you have an unpaid balance (co-pay, co-insurance, deductible, or any out-of-pocket expenses) and you are sent to collections, you will automatically be dismissed from the practice. You will receive a dismissal letter and we will provide the required thirty-day emergency care, allowing you to time to find another dermatologist in the thirty-day period.

There are insurance plans that may require you to have a referral or pre-authorization on-file at the time of your visit. It is **YOUR** responsibility, not Lehigh Valley Dermatology's, to know if your specific insurance plan requires a referral and to obtain one prior to your visit. In the event you fail to obtain a prior authorization and bring it to your visit, your insurance company will deny your claim and you will be financially responsible for the entire visit. Dependent upon the services provided at your visit, it may become quite costly.

If a pre-authorization or referral is not obtained by you prior to your visit and your claim is denied, you will be responsible for the entire balance from your visit. Many insurance companies will deny your claim permanently if your referral is not authorized within 30-60 days.

Laboratory services (like bloodwork) and pathology services are performed by outside laboratories which are financially independent from our office. In the case of pathology services, we will send along all of the insurance information that you give us and the pathology lab will attempt to bill your insurance directly. However, there may be pathology services that your insurance will not cover. Feel free to discuss this directly with the pathology lab and/or your insurance company if you have questions.

If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $36 administrative fee if we are not able to run a new credit card within 7 days. This is comparable to the $36 fee that we charge for returned checks. We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away or to provide a different method of payment.

Finally, when patients make appointments and then either "no show", or cancel the appointment under forty-eight hours' notice, other patients who want to be seen as soon as possible, will not be seen. We do not double-book appointment slots, the time allotted to you goes unused and could have been given to someone else. Therefore, we reserve the right to charge for missed appointments in the range of $120-$200 per visit per patient when not cancelled more than forty-eight hours in advance. If you have a procedure scheduled, you may be charged the equivalent of the procedure you would have received if you would have kept the appointment.

LEHIGH VALLEY DERMATOLOGY ASSOCIATES

190 Brodhead Rd., Suite 205

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Accounts which are past due beyond 60-days are subject to a 1% per month interest charge. In addition, accounts which are more than 90days past due may be subject to an additional $35 processing fee, in addition to the interest charge, and may go to collections. If the account goes to collections, your national credit rating may be

affected. We will make every reasonable effort to work with you to get your balance paid in full. If your account balance is not satisfied through the collections process; we reserve the right to a court hearing where you will be responsible for any court fees in addition to the account balance, and fees listed above.

Lehigh Valley Dermatology's primary purpose is to take care of patients and their families. We hope you now have a clear understanding of our financial policies. These policies exist for one reason only: so that we can concentrate on taking care of patients' medical needs, rather than dealing with insurance companies or trying to obtain balances from unpaid patient bills.

Pre-Authorized Healthcare Form

By signing below, I agree to Lehigh Valley Dermatology's Financial Policy, Referral/Pre-Authorization Policy, Cancellation Policy and Credit Card Authorization. I authorize LVD to charge my credit card/bank card that I present at the time of visit, over the phone or by mail for any outstanding balances. If I choose to pay by any method other than credit card or bank card the alternative payment method does not relinquish me from signing this financial agreement. It simply means that portion of this agreement may not pertain to me at the time I choose to not use a credit card or bank card.

I understand I may be responsible for additional fees which may include: insurance denials for ANY reason (including no referral on file); missed or cancelled appointments; deductibles; co-insurances; partially paid claims; cosmetic procedures; as well as other reasons which may arise. I agree to pay any balance on my account promptly.

If the credit card that I give changes, expires, or is denied for any reason, then I agree to immediately give LVD a new, valid credit card (in a timely manner) which I will allow them to key-in over the phone. Even though LVD is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed herewith and may be used with the same authorization as the original card which I presented in person. In addition, I agree not to initiate or pursue a chargeback or payment reversal after LVD has charged my credit card for any of the above reasons. LVD reserves the right to charge a $36 fee as set in the terms listed previously in this policy. In the event I pay with a check and the check is returned for non-sufficient funds, I agree to provide a LVD with a valid method of payment and to pay the NSF fee of $36.00 promptly.

I understand that I am responsible for payment for all medical and cosmetic services provided to me by LVD. I understand that my insurance may deny or delay payment for these services or only partially pay my claim, and I agree to be financially responsible for any balance that is not covered by insurance or is considered my out-of-pocket portion.

_____ _____

Signature of Patient / or Legal Guardian) Date

_____ _____

Print Name of Person Signing Above Relationship to Patient

Lehigh Valley Dermatology Associates, LTD.

190 Brodhead Rd., Suite 205
Bethlehem, PA 18017

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
(Please print patient name here)

_____
(Signature)

_____
(Date)

_____
(Street Address)

_____
(Phone number)

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name: _____ Phone number: _____

Name: _____ Phone number: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- o The patient refused to sign.
- o Due to an emergency situation, it was not possible to obtain an acknowledgement.
- o We weren't able to communicate with the patient.
- o Other (Please provide specific details)

_____
_____
_____

_____ _____
Patient Signature Date

_____ _____
Employee Signature Date

HIPAA PATIENT COMMUNICATION FORM

A. Family and Friends: It is the office policy of Lehigh Valley Dermatology Associates not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations or (v) other, as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing or call our staff.

Spouse: _____ _____ No

Parent: _____ _____ No

Other: _____ _____ No

_____ _____ No

_____ _____ No

B. Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

_____

PRINTED NAME: _____

Patient/Parent/Guardian Signature: _____

Date: _____

FOR OFFICE USE

Changes to above authorized by patient over the phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lehigh Valley Dermatology Associates, LTD.
190 Brodhead Rd., Suite 120
Bethlehem, PA 18017

Insurance Authorization

Medicare

I request that payment authorized Medicare benefits be made on my behalf to Lehigh Valley Dermatology Associates, LTD. for any services furnished to me by that physician group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signed (insured or authorized person): _____ Date and Time: _____ /_____

Medigap

Name of Medigap Insurer: _____ Medigap Policy#: _____
Medigap Insurer's Mailing Address: _____
_____

I request that payment of authorized Medigap benefits be made to either to me or on my behalf to Lehigh Valley Dermatology Associates, LTD. for any services furnished to me by the physician group. I authorize any holder of medical information about me to release to _____, and its agents any information needed to determine these benefits or the benefits payable to related services.

Signed (insured or authorized person): _____ Date and Time: _____ /_____

Insurance Authorization

I hereby authorize release of any information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Lehigh Valley Dermatology Associates, LTD. I understand that I am financially responsible for any balance not paid by my insurance carrier. I understand my agreement with my insurance carrier is between me and my insurance carrier. LVD is not responsible nor liable to dispute with my insurance company for an unfavorable insurance determination. I am responsible to pay any unpaid balance and have the option to dispute on my own behalf with my insurance carrier for a more favorable outcome. I understand LVD will not wait to receive payment until I receive a more favorable outcome or determination. LVD must be paid promptly upon receiving an invoice for any unpaid portion of my services provided by LVD. I confirm that I do not have any insurance that would prohibit me from being seen at Lehigh Valley Dermatology Associates (i.e. a Medicaid plan).

Signed (insured or authorized person): _____ Date and Time: _____ / _____

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Medical Photography Consent

Patient Name: _____ Date of birth: _____

Patient Address: _____ Phone: _____

I consent for photographs and/or video images to be taken of me or my child by Lehigh Valley Dermatology Associates or its affiliates. I understand the information will be used in my medical record, for purposes diagnosis, tracking my progress, progression of a condition and or treatment, keeping a visual history, medical teaching and reporting to a referring physician. Refusal to consent to photographs will in no way affect the medical care I will receive. However, please keep in mind refusal may limit our ability to track your progress or progression of a condition if we do not have visual documentation. I understand that I am able to withdraw my consent at any time.

- To withdraw my consent in the future I may contact: Practice Manager- Audrey Kovacs - (610) 866-2010
  Office Manager - Kristin Hardiman-Moussa - (610) 866-2010
- Questions pertaining to my rights will be filtered through the Practice Manager or Office Manager

By signing this form below, I confirm that this consent has been explained to me in terms in which I understand.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

_____YES, _____ NO - For educational purposes (medical teaching or training),

_____YES, _____ NO - For marketing and advertising purposes (website, print, digital, or social media),

_____YES, _____ NO - At my request, my photographs and/or video images will only be used as part of my medical record.

If I choose to select the option for consent to marketing and advertising purposes: I hereby release Lehigh Valley Dermatology Associates, LTD., its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation. In the event I selected educational purposes or consent to be part of my medical record only, my information will not be released for marketing. I understand I may change my consent at any time. By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Lehigh Valley Dermatology or by completion of a new form.

Patient Signature: _____ Date: _____

Employee Initials: _____

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ Date of Birth:_____ Medical Record:_____

Patient Address:_____ City, State: _____ Zip: _____

Date Consent Discussed: _____ Physician Name: _____ Location: ____LVD_____

INTRODUCTION Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care, Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

Please initial after reading this page: _____

INFORMED CONSENT FOR TELEMEDICINE PAGE 2

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent, 2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment, 3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee, 4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. LVD has explained the alternatives to my satisfaction, 5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state. 6. I understand that it is my duty to inform LVD of electronic interactions regarding my care that I may have with other healthcare providers. 7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 8. I attest that I am located in the state of Pennsylvania and will be present in the state of Pennsylvania during all telehealth encounters with LVD.

PATIENT CONSENT TO THE USE OF TELEMEDICINE I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Lehigh Valley Dermatology to use telemedicine in the course of my diagnosis and treatment.

PATIENT'S SIGNATURE:_____ DATE: _____
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

_____ WITNESS DATE: _____
IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

_____ DATE: _____
EMPLOYEE SIGNATURE

I have been offered a copy of this consent form. _____

LEHIGH VALLEY DERMATOLOGY associates, ltd.

Name: _____ DOB: _____ Date: _____

Email: _____ Last 4 digits of SS#: _____ Account #: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Do we have permission to leave a message on voicemail or with a family member: ☐ Yes ☐ No

Primary Care Physician: _____

Would you like a letter sent to them: ☐ Yes ☐ No

Past Medical History

☐ Anemia	☐ COPD	☐ Hypertension	☐ Persistent Cough/Cold
☐ Anxiety	☐ Coronary Artery Disease	☐ HIV/AIDS	☐ Post-Menopausal
☐ Arthritis	☐ Currently Pregnant	☐ Hypercholestolemia	☐ Prostate Cancer
☐ Asthma	☐ Depression	☐ Hyperthyroidism	☐ Psychiatric Treatment
☐ Atrial Fibrillation	☐ Diabetes	☐ Hypothyroidism	☐ Radiation Treatment
☐ Bloody Stool	☐ Dizziness/Fainting	☐ Hx Jaundice	☐ Recent weight loss
☐ Bone Marrow Transplant	☐ End Stage Renal Disease	☐ Hx Rheumatic Fever	☐ Ringing in Ears
☐ BPH	☐ Frequent Nose Bleeds	☐ Hx Tuberculosis	☐ Seizures
☐ Breast Cancer	☐ Fever/Chills	☐ Hx Ulcer	☐ Shortness of Breath
☐ Breast Feeding	☐ GERD	☐ Irregular Menses	☐ Sinus Problems
☐ Bruise Easily	☐ Glaucoma	☐ Leukemia	☐ Sore throat/Hoarseness
☐ Chemotherapy	☐ Hearing Loss	☐ Loss of Appetite	☐ Stroke
☐ Chest Pain/Discomfort	☐ Heart Attack	☐ Lung Cancer	☐ Swelling of Ankles
☐ Colon Cancer	☐ Heart Murmur	☐ Lymphoma	☐ Tire easily, weakness
☐ Convulsions/ Epilepsy	☐ Hepatitis	☐ Nipple Discharge	☐ Visual Changes

Other: _____

_____

Surgical History

☐ Appendix _____	☐ Gallbladder _____	☐ Liver _____	☐ Rectum _____
☐ Bladder _____	☐ Heart _____	☐ Ovaries _____	☐ Skin _____
☐ Breast _____	☐ Joint Replacement _____	☐ Pancreas _____	☐ Testicles _____
☐ Colon _____	☐ Kidney _____	☐ Prostate _____	☐ Uterus _____

Other: _____

_____

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking/ Itching Scalp
- ☐ Hay Fever/ Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma

Other: _____

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

Number of blistering sunburns: _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No

If yes, which relative? _____

List All Current Medications

Name:	Strength:	Dosage:	Frequency:

Local Pharmacy: _____

Mail Order Pharmacy: _____

Allergies (Medications/ latex/ epinephrine)

Name:	Reaction:

Social History

Smoking Status:

- ☐ Never
- ☐ Former
- ☐ Current # Packs per Day_____
  # Years Duration_____

EtOH:

- ☐ None
- ☐ Less than one drink per day
- ☐ One to two drinks per day
- ☐ More than three drinks per day

Occupation: _____

Quality Measures

Have you received the influenza vaccine during influenza season? ☐ Yes ☐ No
Why not?_____

Patients 65 and older: Have you received the pneumonia vaccine? ☐ Yes ☐ No
Why not?_____

Do you have a advanced care plan? ☐ Yes ☐ No

Designee: _____

Designee phone number: _____

Do you have a living will? ☐ Yes ☐ No

Which statement best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Family History

History of:

_____
_____
_____
_____
_____

Relationship:

_____
_____
_____
_____
_____

Chief Complaint

Reason for today's visit. If you can, provide additional information about today's complaint including duration prior to

I have either read or been asked and replied to the above questions to the best of my knowledge. I have not omitted any other medical information from my history. I am aware that Lehigh Valley Dermatology Associates Limited are not responsible for medical evaluation of any complaints not related to my skin that have not been attended to by my personal medical physician or primary care physician. I agree to see my primary care physician for any medical conditions I am currently aware of or are detected during medical evaluation that are unrelated to my dermatologic condition.

Finally, I understand that providers encourage a complete skin exam and refusal to have this exam done could have deleterious effects on my health , including failure to detect skin cancer, melanoma, etc. I also understand that the skin is the largest organ of the body and that, it is impossible for providers to be responsible for examining every inch of skin covering my body.

Vitals:

Blood Pressure: _____ Pulse:_____ Respiration:_____

Completed by: _____ Patient

_____ Medical Assistant _____

Reviewed by Physician/ Physician Assistant: _____ Date:_____

Patient Signature:_____ Date:_____

Reviewed by: _____ Date:_____