VUJEVICH DERMATOLOGY ASSOCIATES, PC
DERMATOLOGY & COSMETIC SURGERY CENTER, PC

100 North Wren Drive Pittsburgh, PA 15243
Phone: (412) 429-2570 Fax: (412) 429-2572

95 West Beau Street Washington, PA 15301
Phone: (724) 228-7006 Fax: (724) 228-8822

PATIENT INFORMATION:

Reason for today's visit: _____

Patient Name: _____ ☐ Jr. ☐ Sr.
First *Middle* *Last*

Date of Birth: ____/____/____ Age:____ Social Security #: _____/___/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Address: _____
Street # Street Name Apt/Suite #

_____
City State Zip

Primary Phone: (_____)_____-_____ H W C **Secondary Phone:** (_____)_____-_____ H W C

Email: _____

May we leave personal medical information on your primary or secondary #? YES NO

FAMILY PHYSICIAN/OTHER IMPORTANT INFORMATION

Family Physician: _____ Telephone#: (_____)_____-_____

Do you give our office permission to discuss your medical information with family members or other caregivers? ☐ YES If yes, please provide their names and phone numbers below. ☐ NO

Name: _____Relationship:_____

Phone#: (_____)_____-_____

Name: _____Relationship:_____

Phone#: (_____)_____-_____

Emergency Contact: _____ Relationship to Patient: _____
Phone: (_____)_____-_____

RECEIPT OF NOTICE OF PRIVATE PRACTICES:
My Signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Privacy Practices:
Patient or Responsible Party Signature: _____ **Date:** ____/_____/_____

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INSURANCE AND FINANCIAL

Insurance Information: Do you have health insurance? Yes No (If Yes, please complete below)

Primary Insurance Carrier: _____

Name of Insured (Policy Holder): _____ Policy Holders Date of Birth: ___/___/___

Address of Policy Holder:
Same as patient
Other, please complete here _____
Street # Name City State Zip

Secondary Insurance Carrier: _____

Name if Insured (Policy Holder): _____ Policy Holders Date of Birth: ___/___/___

Do you have an insurance deductible? ☐ **Yes** ☐ **No**
Is your insurance through a hospital group policy? ☐ **Yes** ☐ **No**
(Meaning does the guarantor work for a hospital, affiliate, or university?)
Are you required to use a Home Host Facility for services? ☐ **Yes** ☐ **No**

RELEASE OF INFORMATION/AUTHORIZATION ON FILE

I verify the accuracy of this information and I authorize the release of medical information necessary to process any claims. I request payment of my claims and, if the payer accepts assignment, authorize payment directly to the physician or supplier for the services described.

Patient or Responsible Party Signature: _____ **Date:** ___/___/___

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MEDICAL HISTORY

Patient Name:_____ **DOB:**_____

Amputation	**YES**	**NO**	Hepatitis	**YES**	**NO**
Arthritis	**YES**	**NO**	High blood pressure	**YES**	**NO**
Asthma	**YES**	**NO**	HIV / AIDS	**YES**	**NO**
Autoimmune condition	**YES**	**NO**	Irregular heartbeat	**YES**	**NO**
Bleeding disorder	**YES**	**NO**	Joint replacement	**YES**	**NO**
Blood clot	**YES**	**NO**	Kidney	**YES**	**NO**
Bronchitis / Emphysema	**YES**	**NO**	Limited motion / mobility	**YES**	**NO**
Cancer / Lymphoma	**YES**	**NO**	Lupus	**YES**	**NO**
Crohn's / Ulcerative Colitis	**YES**	**NO**	MRSA infection	**YES**	**NO**
Depression	**YES**	**NO**	Multiple sclerosis	**YES**	**NO**
Diabetes	**YES**	**NO**	Pacemaker / Defibrillator	**YES**	**NO**
Dialysis	**YES**	**NO**	Thyroid	**YES**	**NO**
Epilepsy / Seizures	**YES**	**NO**	Transplant (Organ, Stem cell)	**YES**	**NO**
Fainting	**YES**	**NO**	Valve replacement	**YES**	**NO**
Heart attack	**YES**	**NO**			

Please list any other medical conditions: _____

Please list any surgical procedures you have had: _____

Have you ever had a bad reaction to local anesthesia (ex. Lidocaine)? **YES** **NO**

Skin History:

Have you ever had skin cancer? **YES** **NO** What type? **Basal cell / Squamous cell / Melanoma / Other**

Has anyone in your family had Melanoma skin cancer? **YES** **NO** **Adopted**

If yes, who in your family? _____

Do you develop keloids (thick scars) after surgery? **YES** **NO**

How many times have you used a tanning bed? **Never** **More than 10 times** **More than 100 times**

Social History:

Do you drink Alcohol? **YES** **NO** _____ per day Do you smoke? **YES** **NO** _____ per day

Women only:
Are you pregnant? **YES** **NO**

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The Center for Medicare and Medicaid has implemented changes for 2015. We are required to obtain the following information at each visit.

MEDICATION LIST

ALLERGIES

- _____
- _____
- _____

Patient Name: _____ Date of Birth: _____

Pharmacy Name/Phone: _____

Medication Name	Dose	How often do you take it?

	YES	NO	DATE
Have you had a flu shot?	☐	☐	_____
Have you had a pap smear?	☐	☐	_____
Have you had a mammogram?	☐	☐	_____
Have you had a colonoscopy?	☐	☐	_____

FINANCIAL POLICY/INSURANCE BILLING
VUJEVICH DERMATOLOGY ASSOCIATES, PC

Thank you for choosing us as your health care provider. We are committed to the best of medical and surgical care and would like to make you aware of the following policies.

- Patients **must provide** the office with **accurate insurance information** at the time of their appointment.

- **Insurance benefits** are a **contract** between the **patient** and their **employer/carrier**.

- Insurance coverage varies. Refer to your insurance manual or call your insurance carrier with questions.

- **You are responsible** for non-covered expenses such as deductibles, co-insurances, co-payments, office visits, cosmetic services, or pre-existing conditions. **If you have a deductible**, you must pay your portion to Vujevich Dermatology Associates, PC.

- We do participate with most insurance carriers. However, **if we do not participate with your carrier** or if you do not carry coverage, **you are responsible for payment at the time of service.**

- **We are required by contract to collect** all co-payments, deductibles, or bills **at the time of visit.**

Your signature signifies that you understand our financial policy and your responsibility regarding charges incurred in this health facility.

_____

Patient or Responsible Party Signature **Date**