Skin Cancer
CENTER
of
Northern Virginia

# MEDICAL HISTORY

**FULL NAME:**____________________________ Name you would like us to use: __________________
Were you referred by a physician? Yes / No. If No, how did you find us? ____________________________
If yes, name of referring Dr.: ________________________ Location: ______________________
**Primary Care Physician** : __________________________ Location: ______________________
EMERGENCY CONTACT: __________________ Phone ________________ Relationship: ______________
**Pharmacy Name & Address:**__________________________**Pharmacy Phone:**______________________

## MEDICAL HISTORY

Please list all medications (include over-the-counter): __________________________________________
____________________________________________________________________________________

Do you have any of the following? (If Yes, please explain below)

| | | | |
|---|---|---|---|
| Breathing problems | Yes / No | Artificial heart valve | Yes / No |
| Heart problems | Yes / No | Artificial joint | Yes / No |
| Diabetes | Yes / No | Do you take antibiotics before dentist? | Yes / No |
| High blood pressure | Yes / No | Do you have a pacemaker or defibrillator? | Yes / No |
| Liver problems | Yes / No | Have you had problems with bleeding? | Yes / No |
| Hepatitis | Yes / No | Are you on a blood thinner? | Yes / No |
| Kidney problems | Yes / No | Have you had abnormal scarring (keloid)? | Yes / No |
| Stroke | Yes / No | Do you smoke? Yes / No (If yes, packs/day ________) | |
| HIV / AIDS | Yes / No | Do you wear: glasses contacts dentures hearing aids | |
| Cancer | Yes / No | Do you drink alcohol? Never / Occasionally / Regularly | |
| Organ transplant | Yes / No | | |

Explanation: ___________________________________________________________________________
List all previous surgeries: ________________________________________________________________

**Do you have any drug allergies?** Yes / No. If yes, please list: _____________________________________
____________________________________________________________________________________

## SKIN CANCER HISTORY

Have you ever had skin cancer? Yes / No If yes, what type? ________________________________
Has anyone in your family had skin cancer? Yes / No If yes, explain. __________________________
Do you use a tanning bed? Regularly / Sometimes / Never / Not anymore.
How many blistering sunburns have you had? __________
Have you undergone ultraviolet (PUVA), or radiation treatments? Yes / No ______________________
Do you examine your moles for changes? Yes / No Are any of your moles changing? Yes / No
Occupation (if retired, then prior occupation): _________________________________

## PRIVACY POLICY

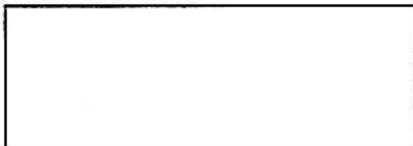
I acknowledge receiving a copy of Loudoun Medical Group's Notice of Privacy Practices. Yes / No

Phone number to call with any biopsy reports or lab results: ________________________ Home / Work / Cell

- ❑ You have my permission to leave a message at the above phone number.
- ❑ Do not discuss my medical care with anyone but me.
- ❑ You have my permission to discuss my medical care with: ___________________________________

__________________________ _______________
**Patient signature / Guardian** **Date**

Initial______ Date________
Initial______ Date________
Initial______ Date________



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Skin Cancer CENTER of Northern Virginia

# PATIENT INFORMATION FORM

**PATIENT INFORMATION** Please PRINT.

Last name: ______________________ First name: ______________________ M.I. ______
SSN#: _____-_____-_______ Sex: M / F Birth Date: ____ / ____ / _______
Address: ____________________________________________________________
City: ______________________ State: ________ Zip: _________
Phone #s Cell: ________________ Work: ________________ Home: ________________
Job Title: ________________________ Employer: ______________________________
Race: ___________ Ethnicity (Please check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Preferred Language (Please check one) ☐ English ☐ Spanish
Status: married, single, widowed, divorced

**INSURANCE HOLDER** - The person who holds the insurance plan – often through employer.

Relationship (ex: self, spouse, father, mother): ________________ If Self, skip this section.
Last name: ______________________ First name: ______________________ M.I. ______
SSN#: _____-_____-_____ Sex: M / F Birth Date: ___ / ___ / _____
Address: ____________________________________________________________
City: ______________________ State: ________ Zip: _________
Phone #s Home: ______________ Work: ________________ Cell: ______________
Job Title: ________________________ Employer: ______________________________

**PRIMARY INSURANCE**
Insurance company: ______________________________
Please bring all insurance cards with you to every office visit. Thank you.

**SECONDARY INSURANCE** (if applicable)
Insurance company: ______________________________

I authorize my insurance benefits to be paid directly to the physician. I acknowledge that I am financially responsible for all charges, and that it is my responsibility to verify that my insurance will cover any procedures that are performed at my request. If my insurance company requires a referral, I understand that it is my responsibility to obtain such a referral prior to my visit. If Medicare or my commercial insurance carrier should deny any charges, then I agree to be personally and fully responsible for any balance due for services rendered. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Loudoun Medical Group (LMG) or any of its affiliates, agents, or lenders. If I fail to meet my financial commitment and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

I authorize LMG to test my blood for hepatitis and HIV if, in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

**Signature:** ______________________________ **Date:** ______________
Initial: __________ Date: __________
Initial: __________ Date: __________
Initial: __________ Date: __________