DERMATOLOGY PRACTICE
OF ROANOKE, P.C.

Dear Patient,

Welcome you to our growing practice! We can't wait to meet you!

We are conveniently located at 2000 Stephenson Ave, Roanoke VA 24014.

We have enclosed a New Patient Information Sheet and a Medical History Form. Please complete these forms and bring them to your appointment. We will also need to make a copy of your insurance card(s) upon arrival, for our records, and will need to see photo id to ensure that you are the patient. This is to protect you and ourselves. We appreciate your patience. Please arrive 15 minutes early to allow time for us to process your insurance and to complete any remaining paperwork before the doctor may see you.

If Dermatology Practice of Roanoke is contracted with your insurance carrier, then you will be responsible only for your co-pay, deductible and co-insurance at the time of service, and as a courtesy we will file the claim for you. If we are not contracted with your insurance carrier, or if you do not have health insurance, then you will be responsible for payment at the time of service.

If you should need to cancel this appointment, please do so within 24 hours so that we can schedule someone else for your appointment time. If you do not show up for your scheduled appointment, you will be charged a fee of $50 per office policy for the physician's time. We appreciate your assistance, as we wish to minimize missed appointments that may be of use to other patients who are ill and need to be seen.

Please be advised that if the patient is a minor, or mentally or physically dependent, he or she must arrive accompanied by a legal guardian or parent with identification, due to laws mandating that we get proper authorization for treatment.

Thank you, and please feel free to call us if you have any questions at (540) 395-3376. We look forward to meeting you soon!

Sincerely,

Dermatology Practice of Roanoke

Chart # _____

PLEASE PRINT INFORMATION BELOW

Patient Name: _____ Age: _____ DOB: _____

Are you allergic to any medications? Yes No If yes, list below:

_____

_____

_____

Please list all medications you are currently taking, or provide a list for us to xerox:

_____

_____

_____

_____

Personal History: (Please circle Y or N)

Thyroid disease	Y / N
Heart disease	Y / N
Pacemaker / defibrillator	Y / N
Irregular heartbeat	Y / N
Artificial heart valve	Y / N
History of clots	Y / N
Lung disease	Y / N
Asthma	Y / N
Diabetes	Y / N
Kidney disease	Y / N
Stomach / bowel disease	Y / N
Hepatitis / Yellow skin	Y / N
Arthritis / Joint deformities	Y / N
Artificial Joints	Y / N
AIDS / HIV infection	Y / N
Tuberculosis or positive PPD	Y / N
Depression	Y / N
Hearing deficit	Y / N
Take aspirin / blood thinners	Y / N

Review of Systems: (Please circle Y or N)

Get stomach upset from antibiotics	Y / N
Get stomach upset from pain medicines	Y / N
Form exuberant scars / keloids	Y / N
Trouble with wound healing	Y / N
Get rashes from tape / bandages	Y / N
Bleed excessively	Y / N
Immunosuppression / frequent infections	Y / N
Get rashes from antibiotics	Y / N
Have enlarged lymph nodes	Y / N
Appetite problems	Y / N
Weight changes	Y / N
Diarrhea / bloody stools	Y / N
Sinus symptoms / infections	Y / N
Boils on the skin	Y / N
Females only:	
Increased body hair	Y / N
Menses irregular / heavy	Y / N

Skin History –Patient and Family: (Please check all that apply)

Disease	*Patient*	*Parent*	*Sibling*	*Other blood relative*
Melanoma				
Other skin cancers				
Atypical / abnormal moles				
Precancerous lesions				
MRSA				
Eczema				
Psoriasis				
Acne				
Accutane therapy				
Seasonal allergies / rhinitis				
Asthma				

Social History: (Please answer all that apply)

Do you smoke? Yes / No If Yes, how much? _____
Do you drink alcohol? Yes / No If Yes, how much? _____
Do you use IV drugs? Yes / No If Yes, how often? _____
Tanning bed use: Yes _____ No _____ Past _____

Females only: Are you pregnant or planning to become pregnant? Yes / No
Are you breastfeeding? Yes / No
Date of last menstrual period: _____

Completed by: Patient / Representative Name (please print): _____

(Signature): _____ Date: _____

Reviewed: Physician Signature _____ Date: _____