VUJEVICH DERMATOLOGY ASSOCIATES, PC

100 North Wren Drive • Pittsburgh, PA 15243 • Phone (412) 429-2570 • Fax (412) 429-2572
95 West Beau Street • Washington, PA 15301 • Phone (412) 429-2570 • Fax (724) 228-8822
521 East Bruceton Road • Pittsburgh, PA 15236 • Phone (412) 429-2570 • Fax (412) 714-4591

PATIENT INFORMATION:

Patient Name: _____ ☐Jr. ☐Sr.
(as it appears on insurance) *First* *Middle* *Last*

Preferred Name: _____ Gender: _____

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

Marital Status: ☐Single ☐Married ☐Divorced/Separated ☐Widow ☐Domestic Partnership
Race/Ethnicity: _____

Address: _____
Street # Street Name Apt/Suite#

_____
City State Zip

Primary Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____
May we leave personal medical information on your identifiable primary or cell #? ☐YES ☐NO

Email (for patient portal access): _____ Occupation:_____

Preferred method of contact for appointment reminders: ☐Voice ☐Email ☐Text

FAMILY PHYSICIAN/OTHER IMPORTANT INFORMATION

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

Do you give our office permission to discuss your medical information with any family members or other caregivers? ☐YES, If yes, please complete the below information. ☐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 (Available on Request):

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

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INSURANCE AND FINANCIAL

YOU DO NOT NEED YOUR INSURANCE CARD TO COMPLETE THIS SECTION.

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 Policy Holder work for a hospital, affiliate, or university?
Where does the Policy Holder work_____*?)*

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 immediate family had Melanoma skin cancer? ☐ **YES** ☐ **NO** ☐ **Adopted**

If yes, who in your immediate family? _____

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

Social History:

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

Women only:

Are you pregnant? ☐ **YES, How far along**_____ ☐ **NO**

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FINANCIAL POLICY/INSURANCE BILLING

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**

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Date Completed: _____
Patient Name: _____
Date of Birth: _____
Pharmacy Name: _____
Pharmacy Phone: _____

Medication Allergies:

- _____
- _____
- _____

NO KNOWN ALLERGIES ☐

MEDICATION LIST:

Medication Name	Dose	How often do you take it?

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Late Cancellation/Missed Appointment Policy

We would like to advise you of our office policy regarding appointment cancellations and missed appointments effective November 15, 2023.

- Any general dermatology appointment no show or cancellation within less than a 24-hour notice will be charged a seventy-five-dollar (**$75.00**) fee. This fee will **not** be covered by your insurance.

- Any cosmetic dermatology appointment no show or cancellation within less than a 24-hour notice will be charged a seventy-five-dollar (**$75.00**) fee.

- If you have a special circumstance regarding a missed appointment, please contact your provider.

- As a courtesy, we will do our best to contact you prior to your appointment. **However, it is your responsibility to remember your scheduled appointments.**

_____	_____	_____
Print Patient Name	**Signature Patient/Guardian**	**Date**