

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
1 Robinson Plaza, Suite 230 • Pittsburgh, PA 15205 • Phone (412) 429-2570 • Fax (412) 659-4559

Patient Information Form

Patient Details:

- **Full Name:** _____ **Preferred Name:** _____
- **Gender:** ☐ Male ☐ Female ☐ Other: _____ **Date of Birth:** ____/____/____ **Age:** _____
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widow ☐ Domestic Partnership
- **Race/Ethnicity:** _____

Contact Information:

- **Address:** _____
City: _____ **State:** _____ **Zip:** _____
- **Primary Phone:** (____) _____ - _____ **Cell Phone:** (____) _____ - _____
- **Permission to Leave Medical Information on your identifiable phone?**
☐ Yes ☐ No (Circle Primary or Cell Phone)
- **Email (for patient portal access):** _____
- **Preferred Contact for Appointments:** ☐ Voice Call ☐ Email ☐ Text

Family Physician & Emergency Contact:

- **Family Physician:** _____ **Phone:** (____) - _____ - _____
- **Emergency Contact Name:** _____ **Phone:** (____) - _____ - _____
Relationship to Patient: _____

Permission to Share Medical Information:

- **Do you authorize us to discuss your medical information with family or caregivers?**
☐ Yes ☐ No (If yes, list below)

Name	Relationship	Phone Number
_____	_____	(____) - _____ - _____
_____	_____	(____) - _____ - _____

Privacy & Consent:

- **I acknowledge that I have received and/or reviewed my physician's Notice of Privacy Practices.**
Patient or Responsible Party Signature: _____ **Date:** ____/____/____

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Insurance and Financial Information

Do you have health insurance? ☐ Yes ☐ No (If yes, complete below)

Primary Insurance:

- Insurance Carrier: _____
- Policy Holder Name: _____ DOB: ____/____/____
- Policy Holder Address: ☐ Same as patient ☐ Other
Address: _____
City: _____ State: _____ Zip: _____

Secondary Insurance (if applicable):

- Insurance Carrier: _____
- Policy Holder Name: _____ DOB: ____/____/____
- Policy Holder Address: ☐ Same as patient ☐ Other
Address: _____
City: _____ State: _____ Zip: _____

Guarantor Information: (who is financially responsible for your medical bills)

- ☐ Self ☐ Other
Guarantor Name: _____
Guarantor Address: _____
City: _____ State: _____ Zip: _____

Additional Insurance Details:

- Is the insurance through a hospital group policy? ☐ Yes ☐ No
If yes, where is the Policy Holder Employed: _____
- Are you required to use a Home Host Facility for services? ☐ Yes ☐ No
Home Host Facility is a specific hospital or clinic that your insurance requires you to go to for certain medical surgical treatments

Release of Information / Authorization

I verify that the above information is accurate and authorize the release of medical information necessary to process claims. I request payment of claims and, if the payer accepts assignment, authorize direct payment to the physician or supplier.

Patient or Responsible Party Signature: _____ Date: ____/____/____

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Medical/Surgical 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 /Lupus	YES	NO	Irregular heartbeat	YES	NO
Bleeding disorder	YES	NO	Joint replacement	YES	NO
Blood clot	YES	NO	Keloid scars	YES	NO
C.O.P.D. / Emphysema	YES	NO	Kidney Disease	YES	NO
Cancer / Lymphoma	YES	NO	Limited motion / mobility	YES	NO
Crohn's / Ulcerative Colitis	YES	NO	Migraine	YES	NO
Depression	YES	NO	MRSA infection	YES	NO
Diabetes	YES	NO	Multiple sclerosis	YES	NO
Dialysis	YES	NO	Pacemaker / Defibrillator	YES	NO
Epilepsy / Seizures	YES	NO	Thyroid Disease	YES	NO
Fainting	YES	NO	Transplant (Organ, Stem cell)	YES	NO
Heart attack	YES	NO	Valve replacement	YES	NO

- **Women only:** Are you pregnant? **YES** (How far along_____) **NO**
- **List any other medical conditions:** _____

- **List any other surgical procedures:** _____

- **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? **Mother** **Father** **Brother** **Sister**

Social History:

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

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Financial Policy/ Insurance Billing

Thank you for choosing us as your healthcare provider. We are committed to providing the highest quality medical and surgical care. Please review our financial policies below:

- Patients must provide accurate and up-to-date insurance information at the time of their appointment.
- Insurance benefits are a contract between the patient and their employer or insurance carrier.
- Coverage varies by plan. Please refer to your insurance manual or contact your insurance carrier with any questions.
- You are responsible for any non-covered expenses, including deductibles, co-insurance, co-payments, office visits, cosmetic services, and pre-existing conditions. If you have a deductible, you must pay your portion to Vujevich Dermatology Associates, PC.
- We participate with most insurance carriers. However, if we do not participate with your plan or if you do not have insurance coverage, full payment is required at the time of service.
- Per our contractual agreements, we are required to collect all co-payments, deductibles, and outstanding balances at the time of your visit.

Your signature acknowledges that you understand and accept our financial policy and your responsibility for charges incurred at our facility.

Patient Printed Name: _____

Patient/Guardian Signature: _____ **Date:** ____/____/____

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Patient Name: _____ Date of Birth: ____/____/____

Pharmacy Name: _____ Phone: (____) ____ - ____

Medication Allergies:

- _____
- _____
- _____

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NO KNOWN ALLERGIES

MEDICATION LIST:

See Attached List

[illegible]

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Appointment Cancellation and No-Show Policy

Effective November 15, 2023, updated March 12, 2025

To provide the best care for all our patients, we ask that you notify us in advance if you need to cancel or reschedule an appointment. Please review our policy below:

- General dermatology appointments: No-shows or cancellations with less than 24 hours' notice will incur a \$75.00 fee, which is not covered by insurance.
- Surgical dermatology appointments: No-shows or cancellations with less than 24 hours' notice will incur a \$75.00 fee, which is not covered by insurance.
- Cosmetic dermatology appointments: No-shows or cancellations with less than 24 hours' notice will incur a \$75.00 fee, which is not covered by insurance.
- If you have a special circumstance that affects your ability to keep an appointment, please contact the office as soon as possible.
- As a courtesy, we will make every effort to remind you of your appointment. However, it is ultimately your responsibility to keep track of your scheduled visits.

Patient Printed Name: _____

Patient/Guardian Signature: _____ **Date:** ____/____/____