Complete Dermatology of Virginia

Dr. Sarah Nakib, MD

10721 Main Street, Building II, Suite 3100
Fairfax, VA 22030
PHONE: (703) 574-7510
FAX: (703) 594-8250

Name: Married Single Widowed Divorced

FIRST MIDDLE LAST

Street Address: Apt/Unit # Mobile Phone:

City State Zip (mobile preferred for appointment reminders)

Work Phone

Email Address

Home Phone

Social Security #

Employment Status/Employer/Occupation

Date of Birth

How did you hear about us?

Gender: Male Female

Ethnicity: Not Hispanic or Not Latino / Hispanic or Latino / Other

Race: Asian / African American / White / Other

Primary Care Physician:

Phone #:

Would you like us to inform your primary care provider of our findings today, with a letter? YES NO

Referring Physician (if different from primary care provider):

Phone #:

Preferred Pharmacy:

Phone #: Location:

-

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Responsible Party Information:

Primary/ Secondary Name on Insurance:

(Person responsible for payment; if different than patient)

Address (if different):

SSS (optional)#: Relationship: Date of Birth:

Phone#:

Emergency Contact Information:

Name: Phone #:

Address: Relationship

I hereby authorize Complete Dermatology of Virginia to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed above. I authorize payment for these services to be made directly to Complete Dermatology of Virginia.

I also understand that I am responsible for payment of services not covered by my insurance company and that payment for co-pays are required at the time of service.

Signature of responsible party: Date: ____/____/_____

Printed Name if not patient:

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Authorization to Release Information:

May we leave messages regarding future appointments on your voicemail? Yes No

May we leave biopsy or test results on a voicemail? Yes No phone number:

I authorize Complete Dermatology of Virginia to discuss my care and/or appointments with the following person(s):

Name:____ Relationship:__________________________

Name:____ Relationship:__________________________

Welcome to Complete Dermatology of Virginia. Our goal is to provide you with the best possible care in a comfortable, friendly environment. In order to minimize the possibility of any miscommunication or misunderstandings we ask that you review the following office policies and indicate your understanding and agreement. If you would like any further clarification, our staff will be happy to assist you. Welcome to the Complete Dermatology of Virginia Family.

Appointment Policies:

In order to provide our patients the most timely care, we ask that you arrive 5 minutes early for your appointment and understand that if you are more than 15 minutes late for your scheduled time it may be necessary to reschedule your appointment for another day. We understand that life happens and sometimes you are unable to make your appointment. Missed appointments happen occasion, however, repeated missed appointments will result in a fee of up to $50 being charged. If you need to cancel your appointment, please notify us at least 24hrs in advance so that we can offer that time to other patients.

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Payment Policies:

In order to keep our costs and fees as low as possible we ask that all Self-pay, Co-Pays and Coinsurance amounts be paid at the time of service.

It is patient's responsibility to know if the doctor being seen at Complete Dermatology of Virginia is in network with their medical policy. If Complete Dermatology of VA is not in network, your insurance company may not pay for some or all the charges associated with your visit. Any remaining charges not paid by the insurance company will be the patient's responsibility.

If your insurance requires a referral, it is the patient's responsibility to ensure that we have received the referral prior to your scheduled appointment. If we have not received your referral prior to your appointment you will be responsible for the full amount of any charges that are not covered by your insurance.

Consent for HIV, Hepatitis B or C Testing:

Complete Dermatology of Virginia is required by section 32.1-45.1 of The Code of Virginia, as amended, to give you notice that if any Complete Dermatology of Virginia health care provider, worker, or employee should be directly exposed to your blood or bodily fluids in any way that may transmit disease, your blood will be required to be tested for infection with the human immunodeficiency virus (AIDS virus) as well as Hepatitis B and C. A physician or other health care provider will notify you of the results of the test. Under VA code section 32.1-45.1A, you are deemed to have consented to the release of the results to the person exposed. Complete Dermatology of Virginia will only be responsible for any expenses incurred for this testing under the circumstances listed above.

I have read and understand the above policies. I have had the opportunity to review the Privacy Practices for Complete Dermatology of Virginia and consent to be bound by those policies.

Signed:____ Date: _____/_____/_____

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CREDIT CARD ON FILE AUTHORIZATION FORM

Effective January 1, 2017 - In response to the recent increasing number of high deductible insurance plans, Complete Dermatology of Virginia will maintain a credit card on file for all patients with commercial health care plans that have not met their annual deductible. Patients with government health care plans (Medicare and Tricare) will not be required to place a credit card on file. For those patients who do not wish to leave a credit card on file, services can still be provided when the minimum fee for each service is paid in full at the time of the visit.

I hereby authorize Complete Dermatology of Virginia to encrypt and charge the credit card listed below for payment of charges to the accounts listed below:

Patient Name: ____ Date of Birth:_________________
Patient Name: ____ Date of Birth:_________________
Patient Name: ____ Date of Birth:_________________
Patient Name: ____ Date of Birth:_________________
(The maximum amount of charges to be authorized per month will be $300.00 per account listed above.)

Card Holder's Name:
____
(Exactly as it appears on the card)

Last 4 digits of credit card authorized to be charged: ____________, if no payment for the service you received is rendered after 90 days of service.

Please give this credit card to the front desk so that it may be stored in our cloud-based practice management system. It will be encrypted.

Card Holder's Signature: ___________________________________ Date:________________

I understand that this form will be kept on file and will remain in effect until the expiration of the credit card. I understand that I may also revoke this form by submitting a written request to the address listed at the bottom of this form. I also understand that I must also submit a written notification to Complete Dermatology of Virginia if the credit card is cancelled, lost or stolen.

Signature:____Date:________________

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(This release of information is optional, it allows us to obtain previous medical records from your previous Dermatologist or Primary Care Physician)

(OPTIONAL)

Patient Name: ______________________________ Date of Birth: ______/______/______

Address: ____

Phone: ______________________________

I authorize ____________________________ **(previous dermatologist or PCP)** to disclose/release the following information.

Last 3 clinic notes and previous pathology reports, lab and imaging result (recommended)

All records

Other ______________________

These records are for services provided on the following date(s): ________________________

** Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/ alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this*

Please send the records listed above to (use this authorization as a cover sheet):

Dr. Sarah Nakib, MD
10721 Main Street, Building II, Suite 3100
Fairfax, VA 22030
(703) 574-7510
***FAX: (703) 594-8250**

The information may be used/disclosed for each of the following purposes:

At my request (only the patient can check this box

Treatment or Consultation

Other ______________________________

This authorization shall expire 6 months from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____ ____________________

Signature of Patient (or patient's personal representative) Date

____ ____________________

Printed Name Relationship of patient representative

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to Complete Dermatology of Virginia 10721 Main Street; Suite 3100 Fairfax, VA 22030

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Patient Name: ____________________________ Date of Birth:____________________________

History and Intake Form

Reason for Visit: ____

Skin Disease History: (please check all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	None

Other:

____

Do you wear Sunscreen? Yes No
If yes, what SPF? ____________________________
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? ____

Medications: (Please list all current medications)

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

Do you take any type of blood thinner? Yes No
Do you take aspirin daily? Yes No

Allergies: (Please list all allergies)

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

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Are you allergic to Latex? Yes No

Are you allergic to Iodine or Betadine? Yes No

Have you ever had a cosmetic procedure done before (e.g. Botox, filler, leg veins, etc.) Yes No

Social History: (Please check all that apply)

- Currently Smokes - daily
- Currently Smokes - not daily
- Has smoked in the past
- Has never smoked
- Drug Use
- None

History and Intake Form (cont.)

Are you pregnant or breastfeeding? Yes No

If you answer yes to above, please select one: pregnant breastfeeding

Past Medical History: (please check all that apply)

Anxiety	Coronary Artery Disease	Hypothyroidism
Arthritis	Depression	Leukemia
Artificial joints	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Pacemaker/Defibrillator
BPH	Hearing Loss	Prostate Cancer
Bone Marrow Transplantation	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	Hypercholesterolemia	Valve Replacement
	Hyperthyroidism	None

Other:____

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Past Surgical History: (please check all that apply)

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colectomy: Colon Cancer Resection
- Colectomy:Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- PTCA
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement, Knee (Right, Left, Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- Joint Replacement within last 2 years
- Kidney Biopsy
- Kidney Removed (Right, Left)
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed: Ovarian Cancer
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP
- Skin Biopsy
- Basal Cell Cancer Surgery
- Squamous Cell Carcinoma Surgery
- Melanoma Surgery
- Spleen Removed
- Testicles Removed (Right, Left, Bilateral)
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer
- None

Other:____

Review of Systems:

Do you have any of the following?

- A pacemaker
- A defibrillator
- Artificial joints that were replaced within the past 2 years
- Artificial heart valve
- Require premedication prior to procedures
- An allergy to adhesive
- An allergy to topical antibiotic ointments
- Pregnant or planning to get pregnant

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An allergy to lidocaine

Experience a rapid heartbeat with epinephrine

Experience yeast infections when taking antibiotics

Experience G.I. upset with antibiotics

Are you ***currently experiencing*** any of the following?

Problems with bleeding

Problems with healing

Problems with scarring (hypertrophic or keloid)

Have any concern with immunosuppression

A changing mole

A rash (diagnosed or undiagnosed)

Abdominal pain

Anxiety

Bloody stool

Bloody urine

Blurry vision

Chest Pain

Cough

Depression

Fever or chills

Headaches

Hay fever

Joint Aches

Muscle weakness

Neck stiffness

Night sweats

Seizures

Shortness of breath

Sore throat

Thyroid problems

Unintentional weight loss

Wheezing