VIRGINIAdermatology
& skin cancer center

PATIENT INFORMATION

Patient Name (Last, First, Middle)	SSN#	Birthdate / / Mm/dd/yy	Sex M F	Referring Doctor
Street Address	City	State	Zipcode	Primary Care Provider
Home Phone Number	Cell Phone/ Daytime number	E mail Address	Marital Status (Circle One) Single Married Widowed Separated Divorced	
Emergency Contact	Phone number	Cell Phone	Relationship to you	

EMPLOYER INFORMATION

Name of Employer	Position	Address	City State Zip	Phone

RESPONSIBLE PARTY INFORMATION

Name (Last, First, Middle)	Street Address	City	State	Zipcode
Home Phone Number	Cell Phone/ Daytime number	Birthdate	Sex M F	Relation to Patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured Relation to patient	Policy Number	Group Number	Effective date

SECONDARY INSURANCE

Name of Insurance Company	Name of Insured Relation to patient	Policy Number	Group Number	Effective date

PRIVACY OPTIONS

☐ **I want NO ONE to receive my Personal Health Information except myself.**

☐ **I request the following person(s) BE ALLOWED to access my Personal Health Information:**

_____ _____

_____ _____

I hereby have read and completed the form above, and all information is true and correct to the best of my knowledge, by signing this form I am consenting for treatment from Virginia Dermatology and Skin Cancer Center, Dr. Brian L Johnson and his staff.

_____ _____ _____

Patient Signature Staff Signature Date

VIRGINIAdermatology
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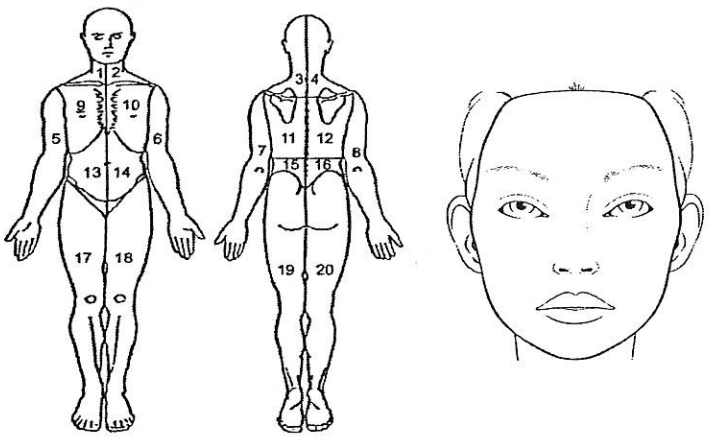
Brian L. Johnson, M.D

DATE: ____/____/____
Name:_____ **DOB:**_____ **Age:**_____ **Gender:** M F
Referring Physician: _____
Which Pharmacy do you use? _____

History & Physical

Where is the lesion? _ (Please Use Picture Diagrams to Mark Lesion)
How long have you known about the lesion? _____
Check All Symptoms:
___Burning ___Itching ___Stinging ___Bleeding
___None ___Other_____



Medications/Vitamins	Allergies

I AGREE TO ALLOW VIRGINIA DERMATOLOGY TO PULL MY MEDICATION RECORDS FROM MY INSURANCE COMPANY. _____ **(INITIAL)**

History of Skin Cancer? _____ **Which Type?**_____
Personal or Family History of Melanoma?_____ **Relation to you**_____
Do you wear sunscreen? _____ **If Yes, What SPF?**_____
Still Working/Retired (circle one)

If any of the following apply to you, please check each....

___Adhesive Allergy	___Anxiety	___Arrhythmia	___Arthritis
___Artificial Joint	___Asthma	___Bleeding Tendencies	___Blood Disorder
___Cancer (etc...)	___Cardiac Valve	___COPD	___Coronary Artery
___Current Infection	___Defibrillator	___Depression	___Diabetes
___GERD	___Hearing Aids	___Heart Attack	___Heart Valve
___Hepatitis	___High Cholesterol	___History of Cold Sores	___HIV/ AIDS
___High Blood Pressure	___Iodine/Shellfish Allergy	___Irregular Heartbeat	___Kidney Problems
___Pacemaker	___Precancerous Moles	___Seizures	___Stroke
___Thick scarring (keloid)	___Thyroid	___Tuberculosis	___Walker Bound
___Wheelchair Bound	___DO YOU NEED ANTIBIOTICS PROIR TO DENTAL WORK (YES/NO)		

Other: _____
Past Surgeries: _____
Do you smoke? Y N **How much:**_____
Do you drink? Y N **How much:**_____
Minimize Smoking as much as possible Prior to and after Surgery ____ Initials
Continue all medication as directed by your doctors including blood thinners ____ Initials
Stop all alcoholic beverages 3 days prior & after surgery ____Initials

---------- Nurse Only----------

Location of lesion: _____ **Histopathology Dx:** _____

Laboratory: _____ **Path#:**_____

Special recommendations: _____

Consult w/plastic date: _____ **MD:**_____ **Phone:** _____

Mohs surgery date/time: _____ **Reconstruction date:** _____

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Thank you for choosing us for your dermatologic healthcare needs. Our staff and physicians are committed to providing you the best service we can.
All patients are required to complete our registration form, provide us with valid medical insurance card and a photo ID, as well as new insurance cards as they become available.

PAYMENT: Payment is expected at the time of your visit. We accept Care Credit, MasterCard, American Express, and Visa in addition to cash and checks. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

INSURANCE: This office has contracts with Medicare and with many other plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurance company about services and physicians before your appointment.
If our doctors are not listed in your plan's network, you will be responsible for payment in full at time of service. As a courtesy, we will prepare and send the claim to your insurer for you.
You are responsible for obtaining a properly dated referral if required by your insurer and are responsible for payment if your claim rejects for the lack of one.

ACCOUNTING PRINCIPLES: Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

RETURNED CHECKS: Returned checks will incur a $50.00 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $50.00 service charge to pay the balance prior to receiving services from our staff or physicians. Stop payment constitutes a breach of payment and are subject to the $50.00 service fee and collections action. All bad checks written to this office are subject to our collections protocol.

CANCELLATIONS OR MISSED APPOINTMENTS: Missed appointments and last minute cancellations affect the schedule of the physician and take an appointment from patients who have a desire or need to be seen. Unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of $50.00 for regular office visits and $100.00 for surgical visits. This fee will not be charged to your insurance company and will need to be paid prior to your next scheduled appointment. Please help us serve you better by keeping your scheduled appointments.

ACKNOWLEDGMENTS/CERTIFICATIONS:

- I was provided the Notice of Privacy Practices on the date of this Agreement.
- I hereby authorize treatment to patient by any Virginia Dermatology and Skin Cancer Center provider and/or affiliated medical staff member(s).
- I authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Medicaid, Medicare or Tricare.
- I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to Virginia Dermatology and Skin Cancer Center for services rendered.
- I understand that if all charges are not paid when due to Virginia Dermatology and Skin Cancer Center, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed THIRTY THREE AND ON-THIRD PERCENT(33-1/3%) of the balance placed with the agency and attorney, which shall be deemed incurred upon referral.

PATIENT(S) NAME(please print)	DATE OF BIRTH

SIGNATURE OF PATIENT/LEGAL GUARDIAN	RELATIONSHIP TO PATIENT/LEGAL AUTHORITY	DATE

VIRGINIAdermatology
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Request and Consent to Photography and/or Video Record

Your provider may need to photograph and/or record you to document a medical condition, help with diagnosis and/or treatment of a condition, and/or to help plan details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission. Your provider does need your written permission to use your photographs and/or recordings for the non-clinical reasons below.

I hereby authorize VIRGINIAdermatology & skin cancer center, including the attending doctor or other designated person(s), to photograph and/or video me for the following purposes: Check **YES** or **NO**.

1. For the advancement of **not-for-profit** medical purposes, including teaching, research, and education. I understand that education is an important part of VIRGINIAdermatology & skin cancer center's commitment to teaching younger healthcare providers.
   YES ☐ **NO** ☐

2. To show or release to current or future VIRGINIAdermatology & skin cancer center patients for the purpose of education and consultation. I understand these photos or videos can be taken at any time during my treatment which includes pre-treatment, post-treatment, pre-operative, intra-operative, post-operative photos, and/or videos of my treatment, surgery and/or procedure.
   YES ☐ **NO** ☐

3. For **external not-for-profit** educational purposes outside VIRGINIAdermatology & skin cancer center such as lectures, presentations at professional conferences, news publications, website publications, social media posts, and email blasts.
   YES ☐ **NO** ☐

I consent to photographs and/or video recordings under the following conditions:

- Copies of the photos, videos, and/or films may be released to me if I ask for them.
- I can refuse to have photos and/or video taken without any change in my medical care at VIRGINIAdermatology & skin cancer center.
- I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or video.
- I understand that once released outside of VIRGINIAdermatology & skin cancer center, VDSCC does not have control over the photos or videos.

Revoking Permission: This authorization has not expiration date; however I may revoke it at any time by writing to VIRGINIAdermatology & skin cancer center at the address below. I must state in writing that I no longer give consent for photo(s) and/or video(s) of for the use of any photo(s) or video(s) that were already taken.

I have read and understand the information. I hereby release VIRGINIAdermatology & skin cancer center, its personnel, and any other persons participating in my care from any and all liability which may or could arise from the taking or authorized use of such photographs and/or video recordings.

_____ _____/_____/_____

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

_____

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship ☐ Spouse ☐ Parent ☐ Next of Kin ☐ Legal Guardian ☐ DPOA for Healthcare

_____ _____/_____/_____

Consent Obtained, Explained and Witnessed By Date (mm/dd/yyy)

5630 Lowery Road Norfolk, VA 23502
Phone: 757-455-5009 Fax: 757-362-3577

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MOHS SURGERY CHECKLIST

- Be prepared to be with us in our office for 4 hours or more.
- Doors open at 7:30am. Patients are seen in the order in which they sign in.
- Bring a lunch and beverage with you because of the length of time you will be with us.
- Bring reading materials.
- Take all of your medications as directed. Do not stop taking any medication unless directed specifically by your prescribing doctor or by Dr. Brian Johnson.
- Get a good night's sleep the night before your scheduled surgery.
- Eat a healthy breakfast before you arrive for surgery.
- Wear comfortable clothes, preferably a button up shirt (so that your shirt is easy to take off without going over the top of your face or the affected surgery site).
- Bring a sweater, as waiting rooms may be chilly.
- Please shower the morning of surgery.
- Please do not wear makeup, hairspray, perfumes, aftershaves, cologne, or scented lotions.

MOHS AFTER SURGERY CARE CHECKLIST

- Make sure you have Extra Strength Tylenol.
- For elderly patients, we recommend that you have a friend or relative with you for the first night after surgery in case of complications. (i.e. bleeding).
- If your wound is on the jaw, cheek, or lip, please have soft food available such as soup, mashed potatoes, gelatin, applesauce and soft cereal options. Meats should be cut into small pieces.

Because we care about our patients' quality of care, we encourage you to call our office and ask to speak with the surgical staff, if you have questions.

(Norfolk) 757.455.5009 (Suffolk) 757.925.1860
(Newport News) 757.369.0469 (Harbour View) 757.967.0790
After business hours, please call 757.650.6147

We appreciate your cooperation in adhering to this checklist. We also would like to thank you for choosing our practice for your dermatological care. High, consistent quality of care is our goal.

Thank you,

Lauren Fobbs, Mohs Patient Care Coordinator 757.455.5009 opt. 2

Brian L. Johnson, M.D.
Fellow, American Academy of Dermatology
Fellow, American Academy of Mohs Micrographic Surgery
And Cutaneous Oncology

www.virginiamohs.com

PATIENT NAME:_____

Surgery Appointment:_____

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