Patient Information

Jordan Valley Dermatology

Virginia L. Tubbs, F.N.P.-C
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Please Complete All Information

First Name	Last Name	M. I.	Date of Birth	Sex	Marital Status	Social Security No.

Mailing Address (Apartment No.)	City	State	Zip	Home Phone

Name of Patient's Employer	Address	City	State	Zip	Work Phone

Email Address	☐ I would like to receive JVD Special Offers in my inbox	Cell Phone

Name of Emergency Contact **NOT** living with you	Relationship	Phone Number

☐ Patient is OVER 18 years of age. If this box is checked move to the insurance information.

Person Responsible For Payment.

Only fill in this box *if* Patient Is Under 18 Years Of Age	Age of Patient	Guarantor's Relationship to Patient

All Following information is in regards to the Guarantor.

First Name	Last Name	M. I.	Date of Birth	Sex	Marital Status	Social Security No.

Mailing Address (Apartment No.)	City	State	Zip	Home Phone

Name of Guarantor's Employer	Address	City	State	Zip	Work Phone

☐ I do **NOT** have insurance coverage at this time and will be paying out of pocket.

Insurance Coverage - #1 (Primary) *We Will Need Copies Of Insurance Cards*

Insurance Company #1		Primary's Phone	
Primary Insured Person	Primary Insured's D.O.B	Relationship to Patient	
Mailing Address of Primary Person Insured	City	State	Zip
Social Security No.	Insurance ID No.	Group No.	
Name of Employer			

Insurance Coverage - #2 (Secondary) *We Will Need Copies Of Insurance Cards*

Insurance Company #2		Primary's Phone	
Primary Insured Person	Primary Insured's D.O.B	Relationship to Patient	
Mailing Address of Primary Person Insured	City	State	Zip
Social Security No.	Insurance ID No.	Group No.	
Name of Employer			

Medical and Financial Information Authorization Release

In general, the Health Information Portability and Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication or PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. We will release information **ONLY** by the means you authorize in this form. We will take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. We will keep a record of all PHI disclosures. Uses and disclosures may be permitted without prior consent in an emergency.

I authorize the staff of this Clinic to ***release*** any ***financial*** information to the following people:

Name of Spouse: _____

Name of Partner: _____

Name of Parent or Guardian: _____

Other: _____

I authorize the staff of this Clinic to ***release*** any ***medical*** information to the following people:

Name of Spouse: _____

Name of Partner: _____

Name of Parent or Guardian: _____

Other: _____

I can be contacted by phone (__ __ __) - __ __ __ - __ __ __ __

I give my permission to leave a message at this phone number. Yes / No

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I understand I may revoke any part of this authorization at any time by giving written notice to the Privacy/Security Officer in our Clinic.

Patient Signature _____ Date _____

Parent or Guardian Signature: _____ Date: _____

Financial and Insurance Requirements

- Effective October 1st, 2017 each patient will be asked whether or not their annual deductible and out of pocket have been met for the current calendar year. If it ***has not*** been met for the current calendar year we will ask for your co-pay. If you do not know your co-pay amount and it is not printed on the front of your insurance card, we will collect a fee of $60. Full payment is expected at the time of visit.

- It is the patient's responsibility to know if their out of pocket and annual deductible are met for the current calendar year. Once the claim has been processed by your insurance and it is found you have over paid, we will issue a refund for the overpayment. Refunds are issued on a monthly basis.

- If you are covered by Medicare or Veteran services, we will **not** collect payment for today's visit. We will bill your insurance for you

- If you are an ***adult*** covered by Medicaid you will be charged $2.45 for today's visit and we will bill your insurance for you. If you are ***under 18*** and covered by Medicaid, we will bill your insurance for you.

- We can extend a payment plan to you if you have need. Please discuss this with provider before services are rendered.

- All cosmetic patients are considered cash-pay patients as none of the procedures for cosmetic treatments are eligible for insurance billing. Payment is expected at time of service.

- If you are considering bio-identical hormone treatments through Health Optimization LLC, be advised that these services are rendered through a separate company, which does not have any contracts with any insurance companies. Services rendered for Health Optimization LLC are not eligible for insurance billing. Payment for services rendered through Health Optimization LLC are expected at time of service.

Patient Signature _____ Date _____

Parent or Guardian Signature:_____ Date: _____

Patient History

Patient Name: _____ DOB: _____ Today's Date: _____

Reason for today's visit : _____

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

Have you ever had bad reaction to dental anesthesia (Novocaine)? ◯Yes ◯No If yes, list : _____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals): _____

Select any of the following medical conditions that you currently have.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Enlarged Prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

List any other diseases or conditions: _____

Have you had any surgeries on the following organs? If yes, please explain.

Appendix: _____
Bladder: _____
Breast: _____
Colon: _____
Gallbladder: _____
Heart: _____
Joint Replacement: _____
Kidney: _____
Liver: _____
Ovaries: _____
Pancreas: _____
Prostate: _____
Rectum: _____
Skin: _____
Spleen: _____
Testicles: _____
Uterus: _____

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell skin cancer
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell skin cancer

Do you wear sunscreen? ◯ Yes ◯ No

Do you drink alcohol? ◯ Yes ◯ No If yes, _____ drinks per day.

Do you use tobacco? ◯ Yes ◯ No If yes, what and how much? _____

Are you pregnant? ◯ Yes ◯ No Due Date: _____

What is your occupation? _____

Which pharmacy do you prefer? _____

Patient - or - Guardian Signature: _____ **Date:** _____

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