V DERMATOLOGY- MEDICAL HISTORY

Name: _____ Occupation: _____

DOB: ___/____/_____ Age: _____ Sex: _____ Referred by:_____

Primary Care Physician: _____

Preferred Pharmacy: _____ Email Address: _____

Primary Insurance: _____ Secondary: _____

PAST MEDICAL HISTORY: (circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Covid-19 Vaccine
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism (high)
Hypothyroidism (low)
Leukemia
Lung Cancer
Lymphoma
Pneumonia Vaccine
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

PAST SURGICAL HISTORY: (please list): NONE

_____

_____

SKIN DISEASE HISTORY: (circle all that apply)

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

Do you wear sunscreen? YES NO If yes, what SPF? _____ Do you tan indoor/outdoor? YES NO

Do you have a family history of melanoma? YES NO If yes, which relative(s)? _____

MEDICATIONS: (Please list all current medications/dose) – Or give a copy to the front desk staff to enter in manually

_____

_____

ALLERGIES: (please list all allergies to medications)

SOCIAL HISTORY:

Do you smoke? Yes__ No__ If yes, how much? _____ **If no**, have you smoked in the past? Yes__ No__

Do you drink alcohol? Yes___ No___ If yes, _____drinks per day/week/month

Do you have a family history of cancer (other than skin)? YES NO If yes, type of cancer(s)? _____

Which relative(s)? _____

REVIEW OF SYSTEMS: Do you **CURRENTLY** have any of the following? Circle **Y for YES** or **N for NO**

GENERAL:			
Fever	Y N	**NEUROLOGICAL:**	
Weight Loss	Y N	Headaches	Y N
Blurred Vision	Y N	Seizures	Y N
Sore Throat	Y N	**RESPIRATORY:**	
ENDOCRINE:		Chronic Cough	Y N
Thyroid Problems	Y N	Shortness of Breath	Y N
CARDIOVASCULAR:		Wheezing	Y N
Chest Pain	Y N	**HEMATOLOGY:**	
Swelling of Extremities	Y N	Abnormal Bleeding	Y N
GASTROINTESTINAL:		**INTEGUMENTARY:**	
Abdominal Pain	Y N	Problems with Healing	Y N
Bloody Stool	Y N	Problems with Scarring	Y N
Bloody Urine	Y N	Rash	Y N
MUSCULOSKELETAL:		**PSYCHIATRIC:**	
Joint Pain	Y N	Anxiety	Y N
Muscle Pain or Weakness	Y N	Depression	Y N

ALERTS: (circle all that apply)

Allergy to Adhesive
Allergy to Topical Antibiotics
Artificial Joint Replacement
Defibrillator
Pacemaker
Latex Allergy
Rapid heart with epinephrine
Allergy to Lidocaine
Artificial Heart Valve
Blood Thinners
MRSA
Pregnant or trying to get pregnant
Breastfeeding

Require antibiotics prior to a dental/surgical procedure Reason: _____

Race: _____ or DECLINE Ethnic Group: _____ or DECLINE

Preferred Language: ENGLISH or Other: _____

PATIENT SIGNATURE: _____ Staff Initials _____

Patient Name:_____ Patient Date of Birth:_____

Anthony Van Vreede, MD
1225 W. Front St, Suite C
Traverse City, MI 49684
(P) 231-642-5031 – (F) 231-525-2306

HIPAA CONSENT FORM

By listing the persons below, I am authorizing any employee of V Dermatology, to release information contained in my patient records to the individuals listed below, only under the conditions listed below:

___ Do not release any information to anyone.

I authorize information to be released to (PLEASE PRINT NAMES & RELATIONSHIPS):

_____

_____

Primary Care Provider:_____

Without expressed written revocation this authorization will remain in effect from date of signature. I acknowledge that I have been offered a copy of V Dermatology's notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.

Patient Signature:_____ Date:_____

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INSURANCE SIGNATURE ON FILE CONSENT FORM

I certify that the information given by me in applying for Insurance and/or Medicare payment is true and correct.

I authorize my doctor to act as my agent in helping me obtain payment of my Insurance and/or Medicare benefits, and I authorize payment of these benefits to Dr. Anthony Van Vreede on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer of the agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature: _____ Date:_____

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NO SHOW POLICY CONSENT FORM

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, patients who do not show up for their appointment without a call to cancel at least 24 hours before the appointment time will be considered as NO SHOW.

V Dermatology has the right to charge a fee of $50.00 for all missed appointments ("no shows").

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid in full prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Signature:_____ Date: _____

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CONSENT TO BE PHOTOGRAPHED-EDUCATIONAL USE ONLY

I consent for medical photographs to be taken of me by the staff or representatives of V Dermatology. I understand that the images will be placed in my medical record and may be used for a variety of purposes, including monitoring my response to treatments and confirming lesion sites. The photos may also be used for educational purposes such as patient education including Dr. Van Vreede's cosmetic or surgical portfolio and website, educational presentations for community members or physicians/healthcare practitioners. By consenting to these medical photographs, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

I also give permission for transfer of these photographs via a non-encrypted email exclusively for the purposes of third-party diagnostics, treatment and continuing medical care (e.g. communication with my primary care physician).

Refusal to consent to photographs will in no way affect the medical care I will receive.

If I wish to withdraw my consent in the future, I may do so with a written request.

Patient Signature:_____ Date:_____

1225 W. Front Street – Suite C, Traverse City, MI 49684
Anthony Van Vreede, MD

CONSENT AND AUTHORIZATION FOR SURGICAL PROCEDURES

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of Anthony Van Vreede, MD. This may include, but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, cryotherapy, electrocautery and destruction, surgical removals, or excisions), or other services rendered during my visit with Anthony Van Vreede, M.D. at V Dermatology.

In order to ensure that you understand all aspects of your visit, we encourage you to ask any questions regarding any procedures prior to them being performed. Dr. Van Vreede and staff will answer any questions and discuss any procedures and concerns with you in regard to the following:

- Benefits of the proposed procedure.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.
- The right to withdraw informed consent at any time, in writing.

Should a biopsy/culture be performed, or any other procedure in which a sample or section of your skin is removed, the specimen will be sent to an outside pathology lab (Pinkus/Aurora, St. Joseph Mercy, Munson, and CTA) for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges. Billing questions regarding pathology lab charges should be addressed with the pathology lab itself. A staff member from V Dermatology will call you in approximately 7-10 days to inform you of your results.

I acknowledge that some medical diagnoses (such as warts, pre-cancerous, irritated moles) will require multiple treatments with one or more methods that may change throughout the course of treatment according to the provider's treatment recommendation. I understand that each office visit and procedure will be billed accordingly.

With any procedure, there are risks involved which include, but are not limited to the following:

• Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed. (Scaring can be hypertrophic, red, hyper/hypopigmented, uneven, etc.)

• Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.

• Bleeding – Some procedures may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.

• Nerve damage – Some procedures may create temporary nerve damage and/or abnormal nerve sensation.

• Recurrence – Recurrence is possible if the lesion is not completely removed. We will do everything we can to remove the lesion in its entirety, however since they grow microscopically, it is possible that the entire lesion is not removed.

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at V Dermatology. I do not impose any limitations on V Dermatology and its staff. I understand that I should discuss any questions or concerns with Dr. Van Vreede prior to any procedure and; therefore, with my signature, agree to have any necessary procedures performed.

PATIENT PRINT: _____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____