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**PLEASE COMPLETE  
 ALL LINES!**

600 Peter Jefferson Parkway, Suite 230  
 Charlottesville, VA 22911  
 (434) 984-2400

CHART# \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security #	D.O.B.
Home Address:	City	State	Zip
Mailing address if different than home	City	State	Zip
Home Phone #	Mobile #	Work Phone #	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Emergency Contact of person not living with you	Phone #	<b>E-MAIL Address(please print)</b>	

**PARENT OR RESPONSIBLE PARTY (if different from patient)**

Name:	First	Last	M.I.
Home Address:	City		State Zip
Mailing Address if different than home	City		State Zip
Home Phone #	Work Phone #		Social Security #
D.O.B.	D.O.B. of Policy Holder	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Place of Employment Place of Employment of Policy Holder
<b>Primary Insurance</b>			<b>Secondary Insurance</b>
<b>Policy Holder</b>			<b>Policy Holder</b>

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "Crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits of or the benefits payable for related services.

\_\_\_\_\_  
 Signature as it appears on MEDIGAP Card

\_\_\_\_\_  
 Date

<b>Primary Care Physician</b>	<b>Referred By</b>
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In your own words please state the reason for your visit \_\_\_\_\_

List ALL medications you are currently taking (including over the counter medication) \_\_\_\_\_

List ALL drugs or environmental allergies \_\_\_\_\_

**PAST MEDICAL HISTORY**

List other problems you may have with your skin, hair, nails, or mucous membranes \_\_\_\_\_

**Please check if you have any of the following:**

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Artificial Heart Valve       | <input type="checkbox"/> Eczema                      | <input type="checkbox"/> HIV Infection         | <input type="checkbox"/> Organ Transplantation | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Artificial Joints/ materials | <input type="checkbox"/> Epilepsy/seizures           | <input type="checkbox"/> Keloids/Thick Scar    | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Fainting Tendencies         | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Rheumatic Diseases    | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Bleeding Tendency            | <input type="checkbox"/> Genetic Diseases            | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Severe Headaches      | <input type="checkbox"/> Urticaria (Hives) |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Hay fever (Sinus Allergies) | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Skin Cancer           | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Chemotherapy                 | <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Skin Infection        | <input type="checkbox"/> X-ray treatments  |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tanning Bed Use       |  |

Comments \_\_\_\_\_

**When exposed to sunlight do you :**  Always Burn  Often Burn, Tan Slowly  Rarely Burn, Always Tan  
 Usually Burn, Rarely Tan  Sometimes Burn, Tan Well  Never Burn

**WOMEN ONLY**

Are you or might you be pregnant?  Yes  No  
 Are you planning or attempting to become pregnant in the near future?  Yes  No  
 Are you on Birth Control Pills?  Yes  No Brand \_\_\_\_\_

I am able to obtain a copy of the privacy policy that is posted in the office anytime that I request.

\_\_\_\_\_

Initials \_\_\_\_\_  
Date

Many time parents find themselves unable to accompany their young children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant \_\_\_\_\_ permission to treat my child when they arrive at the office unaccompanied.

\_\_\_\_\_

Initials \_\_\_\_\_  
Date

Do we have permission to:

Leave a message on your answering machine at home?  Yes  No      • May we mail results to address on file?  Yes  No

Leave a message at your place of employment  Yes  No

Discuss your medical condition with any member of your household?  Yes  No

If yes, whom: \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_

Patient Signature/Guardian \_\_\_\_\_  
Date

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and all members of my family promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection on any proceeds of insurance.

I herby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay the collection agency fees, court costs, and attorney fees. All return checks will be charged a \$50.00 return check fee.

Your copay is expected at the time of service, if you do not pay on the day of your appointment a \$10.00 billing fee will be added to your account.

Our office requires a 24 hour notice regarding a cancellation of an appointment. If we do not receive the 24 hour notice the fee for an office appointment is \$50.00. The cancellation fee for surgery is \$100.00.

**SKIN PRODUCTS - NON RETURNABLE/NONREFUNDALBE**

**We sell a variety of skincare products in our office as a convenience to our patients. We may recommend a certain product to you, but these products are not required. It is possible that you may find a comparable product elsewhere.**

\_\_\_\_\_

Signed (patient) \_\_\_\_\_  
Date

\_\_\_\_\_

Signed (gurarantor) \_\_\_\_\_  
Date

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS [formely HCFA]) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the third party that accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.). Regulations pertaining to Medicare assignment of benefits also apply.

\_\_\_\_\_

Signed(patient) \_\_\_\_\_  
Date

Are you interested in completing a short cosmetic questionnaire?  Yes  No

\_\_\_\_\_

Signature \_\_\_\_\_  
Date