VUJEVICH DERMATOLOGY ASSOCIATES, PC

100 North Wren Drive ● Pittsburgh, PA 15243 ● Phone (412) 429-2570 ● Fax (412) 429-2572
95 West Beau Street ● Washington, PA 15301 ● Phone (412) 429-2570 ● Fax (724) 228-8822
521 East Bruceton Road ● Pittsburgh, PA 15236 ● Phone (412) 429-2570 ● Fax (412) 714-4591

Patient Information Form

Patient Details:

- **Full Name: ____ Preferred Name: ___________________**
- **Gender: ☐ Male ☐ Female ☐ Other: ______________ Date of Birth: ____/____/_____ Age: ______**
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widow ☐ Domestic Partnership
- **Race/Ethnicity:** ___________________

Contact Information:

- **Address: ____**
  City: _________________________ State: ________ Zip: _________
- **Primary Phone: (_____) ______ -_________ Cell Phone: (_____) ______ -_________**
- **Permission to Leave Medical Information on your identifiable phone?**
  ☐ Yes ☐ No (Circle Primary or Cell Phone)
- **Email (for patient portal access): ____**
- **Preferred Contact for Appointments: ☐ Voice Call ☐ Email ☐ Text**

Family Physician & Emergency Contact:

- **Family Physician: _________________________________ Phone: (_____) -_______-________**
- **Emergency Contact Name: _________________________ Phone: (_____) -_______-________**
  Relationship to Patient: _______________________

Permission to Share Medical Information:

- **Do you authorize us to discuss your medical information with family or caregivers?**
  ☐ Yes ☐ No (If yes, list below)

Name	Relationship	Phone Number
______________________________	______________	(_____) -_______-________
______________________________	______________	(_____) -_______-________

Privacy & Consent:

- **I acknowledge that I have received and/or reviewed my physician's Notice of Privacy Practices.**
  Patient or Responsible Party Signature: ____________________________ Date: ____/____/____

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Insurance and Financial Information

Do you have health insurance? ☐ Yes ☐ No (If yes, complete below)

Primary Insurance:

- **Insurance Carrier: ____**
- **Policy Holder Name: ____ DOB: ____/____/_____**
- **Policy Holder Address: ☐ Same as patient ☐ Other**

  Address: ____

  City: __________________________ State: ________ Zip: _________

Secondary Insurance (if applicable):

- **Insurance Carrier: ____**
- **Policy Holder Name: ____ DOB: ____/____/_____**
- **Policy Holder Address: ☐ Same as patient ☐ Other**

  Address: ____

  City: __________________________ State: ________ Zip: _________

Guarantor Information: (who is financially responsible for your medical bills)

- **☐ Self ☐ Other**

  Guarantor Name: ____

  Guarantor Address: ____

  City: __________________________ State: ________ Zip: _________

Additional Insurance Details:

- **Is the insurance through a hospital group policy? ☐ Yes ☐ No**

  If yes, where is the Policy Holder Employed: __________________________

- **Are you required to use a Home Host Facility for services? ☐ Yes ☐ No**

  Home Host Facility is a specific hospital or clinic that your insurance requires you to go to for certain medical surgical treatments

Release of Information / Authorization

I verify that the above information is accurate and authorize the release of medical information necessary to process claims. I request payment of claims and, if the payer accepts assignment, authorize direct payment to the physician or supplier.

Patient or Responsible Party Signature: _______________________ Date: _____/_____/______

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Medical/Surgical History

Patient Name: ____DOB: _________________

Amputation	YES	NO	Hepatitis	YES	NO
Arthritis	YES	NO	High blood pressure	YES	NO
Asthma	YES	NO	HIV / AIDS	YES	NO
Autoimmune condition /Lupus	YES	NO	Irregular heartbeat	YES	NO
Bleeding disorder	YES	NO	Joint replacement	YES	NO
Blood clot	YES	NO	Keloid scars	YES	NO
C.O.P.D. / Emphysema	YES	NO	Kidney Disease	YES	NO
Cancer / Lymphoma	YES	NO	Limited motion / mobility	YES	NO
Crohn's / Ulcerative Colitis	YES	NO	Migraine	YES	NO
Depression	YES	NO	MRSA infection	YES	NO
Diabetes	YES	NO	Multiple sclerosis	YES	NO
Dialysis	YES	NO	Pacemaker / Defibrillator	YES	NO
Epilepsy / Seizures	YES	NO	Thyroid Disease	YES	NO
Fainting	YES	NO	Transplant (Organ, Stem cell)	YES	NO
Heart attack	YES	NO	Valve replacement	YES	NO

- **Women only: Are you pregnant? YES (How far along_______) NO**
- **List any other medical conditions: ____**

  ____
- **List any other surgical procedures: ____**

  ____
- **Have you ever had a bad reaction to local anesthesia (ex. Lidocaine)? YES NO**

Skin History:

- **Have you ever had skin cancer? YES NO**

  What type? Basal cell / Squamous cell / Melanoma / Other
- **Has anyone in your immediate family had Melanoma skin cancer? YES NO Adopted**

  If yes, who in your immediate family? Mother Father Brother Sister

Social History:

- **Do you drink Alcohol? YES_____ per day NO**
- **Do you smoke? YES_____ per day NO**

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Financial Policy/ Insurance Billing

Thank you for choosing us as your healthcare provider. We are committed to providing the highest quality medical and surgical care. Please review our financial policies below:

• Patients must provide accurate and up-to-date insurance information at the time of their appointment.

• Insurance benefits are a contract between the patient and their employer or insurance carrier.

• Coverage varies by plan. Please refer to your insurance manual or contact your insurance carrier with any questions.

• You are responsible for any non-covered expenses, including deductibles, co-insurance, co-payments, office visits, cosmetic services, and pre-existing conditions. If you have a deductible, you must pay your portion to Vujevich Dermatology Associates, PC.

• We participate with most insurance carriers. However, if we do not participate with your plan or if you do not have insurance coverage, full payment is required at the time of service.

• Per our contractual agreements, we are required to collect all co-payments, deductibles, and outstanding balances at the time of your visit.

Your signature acknowledges that you understand and accept our financial policy and your responsibility for charges incurred at our facility.

Patient Printed Name: ________________________________

Patient/Guardian Signature: __________________________ **Date:** _____/_____/______

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Patient Name: ______________________________ Date of Birth: ____/_____/_______

Pharmacy Name: ____________________________ Phone: (____) _____-________

Medication Allergies:

- ______________________________
- ______________________________
- ______________________________

☐ **NO KNOWN ALLERGIES**

MEDICATION LIST:

☐ **See Attached List**

Medication Name	Dose	How often do you take it?

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Appointment Cancellation and No-Show Policy

Effective November 15, 2023, updated March 12, 2025

To provide the best care for all our patients, we ask that you notify us in advance if you need to cancel or reschedule an appointment. Please review our policy below:

• General dermatology appointments: No-shows or cancellations with less than 24 hours' notice will incur a $75.00 fee, which is not covered by insurance.

• Surgical dermatology appointments: No-shows or cancellations with less than 24 hours' notice will incur a $75.00 fee, which is not covered by insurance.

• Cosmetic dermatology appointments: No-shows or cancellations with less than 24 hours' notice will incur a $75.00 fee, which is not covered by insurance.

• If you have a special circumstance that affects your ability to keep an appointment, please contact the office as soon as possible.

• As a courtesy, we will make every effort to remind you of your appointment. However, it is ultimately your responsibility to keep track of your scheduled visits.

Patient Printed Name: ________________________________

Patient/Guardian Signature: __________________________ Date: _____/_____/______