Delmarva Dermatology LLC Patient Information Form 2025

Date	**First Name**
Last Name	**Middle Name or Initial**
Preferred Language	
Gender	
Race	
Ethnicity	
Date of Birth:	
Address	
City	**State**
Zip Code	

Additional Contact Information

Primary Phone Number	**Cell Phone**
Work Phone	**E-mail Address**
Best number for reminder calls ❑ Primary ❑ Cell ❑ Work	

Emergency Contact Information

Emergency Contact Name	**Emergency Contact Relationship**
Emergency Contact Phone	**Emergency Contact Secondary Phone**

Primary Care Physician / Pharmacy Information

Primary Care Physician	**Office Phone Number**
Office FAX Number	
Preferred Pharmacy Name and Location	
Pharmacy Phone Number	

Medical Insurance Information

Primary Medical Insurance Company	**Group Number**
Member ID or Policy Number	**Policy Start Date**
Policy Holder Name	**Policy Holder DOB**
Policy Holder Relationship to Patient	
Co-Pay Amount	

Referral Required to see Specialist?	
Insurance Company Address on Card	
Insurance Company Phone Number on Card	
Additional Information	
Secondary Insurance Company	**Group Number**
Member ID or Policy Number	**Policy Holder Name**
Policyholder DOB	
Additional Information	

Guarantor, Guardian, Responsible Party

If the patient is a minor or under the care of a legal guardian, please fill in this section.	
Legal Guardian Name	
Relationship	**Phone**
Street Address	
City	**State**
Zip	**Country**
I hereby agree to be both financially and legally responable for the services the minor is to receive. I affirm, under penalty of perjury, that I am the legal guardian of the person under my guardianship.	
Guardian Name	
Signature: _____	
Date:	

Authorization Information

I have read the Notice of Privacy Practices document which contains a Health Insurance Portability and Accountability Act of 1996 (HIPAA) notice on the Delmarva Dermatology, LLC website (DmvDerm.com) By signing below, I verify that I have read the above referenced document and entering my name constitutes a valid electronic signature.
Signature: _____
Date:
I have read the Office Policies document which contains important information regarding services and payment. This document is provided on the Delmarva Dermatology, LLC website - DmvDerm.com By signing below, I verify that I have read the above referenced document and entering my name constitutes a valid electronic signature.
Signature: _____
Date:

I hereby authorize Delmarva Dermatology, LLC to release any information necessary for my course of treatment. I also authorize the release of medical information to anyone which Delmarva Dermatology, LLC may release billing or patient care information on a regular basis. In addition, I hereby authorize the release of information to the family members and/or personal acquaintances named below.

Name and Relationship of family or personal acquaintances to whom you authorize the release of information.

Name	Relationship

By signing below, I verify the above information is correct to the best of my knowledge and that entering my name constitutes a valid electronic signature.

Signature: _____

Date:

We will bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of any co-payments due at the time of service and on receipt of a bill for any deductible and/or co-insurance due as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your health care provider elect to continue treatment past your approved period, you will be responsible for your account balance in full. If your insurance policy requires a referral to see a specialist, it is your responsibility to obtain any required insurance referrals prior to being seen in our office. If you do not obtain your insurance referral, we can either reschedule you for a future date, or you can choose to Self-Pay at the time of service. If you choose to self pay, we are not permitted to file a claim through your insurance for the visit.

I have read and understand the above billing and payment policy.

Signature: _____

Medical History 1

Patient Name

Date of Birth

Please fill out the following:

Medication Allergies	What Happens?

Please fill out the following:

List of Current Medications (OTC and Prescription)	Reason for Medication	Dosage (i.e. mg)	How Many Times a day	Route (e.g. Oral, Topical, Injection, Ear, Eye)

Please fill out the following:

Medical Conditions Known to the Patient:

If you have ever been hospitalized, please list the dates and reason.

Year	Problem / Surgery

Skin Disease History

Have you had any of the following skin conditions? Please check all that apply.

- ❑ None
- ❑ Actinic Keratoses
- ❑ Basal Cell Skin Cancer
- ❑ Dry Skin
- ❑ Flaking or Itchy Scalp
- ❑ Melanoma
- ❑ Precancerous Moles
- ❑ Squamous Cell Skin Cancer
- ❑ Acne
- ❑ Asthma
- ❑ Blistering Sunburns
- ❑ Eczema
- ❑ Hay Fever / Allergies
- ❑ Poison Ivy
- ❑ Psoriasis

Other

If you have had skin cancer removed in the past, please list Type, Location, How it was Treated, and the Year

Type of skin cancer (Basal Cell, Squamous Cell, Melanoma, Other)	Location of skin cancer	How was it treated? (Mohs, Excision, Cream, Scraping)	Year it was Treated

Does anyone in your family have a history of the following? Please check all that apply:

- ❑ Allergies
- ❑ Asthma
- ❑ Cancer
- ❑ Cancer of the Skin
- ❑ None
- ❑ Dermatittis
- ❑ Eczema
- ❑ Psoriasis
- ❑ Melanoma

If you answered Yes for family history of melanoma, please indicate the relationship.

Medical History 2

Please answer Yes or No to the following:

Allergy to Adhesive	❑ Yes	❑ No	Allergy to Lidocaine	❑ Yes	❑ No
Allergy to Topical Antibiotic Ointments	❑ Yes	❑ No	Artificial Heart Valve	❑ Yes	❑ No
Artificial Joints within the Past 2 Years	❑ Yes	❑ No	Blood Thinners	❑ Yes	❑ No
Defibrillator	❑ Yes	❑ No	MRSA	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No	Premedications Prior to Procedures	❑ Yes	❑ No
Rapid Heartbeat with Epinephrine	❑ Yes	❑ No	Current Pregnancy or Planned Pregnancy	❑ Yes	❑ No
Received Flu Vaccination for Current Flu Season	❑ Yes	❑ No	Swollen Lymph Nodes	❑ Yes	❑ No
Problems with Bleeding	❑ Yes	❑ No	Problems with Healing	❑ Yes	❑ No
Problems with Scaring (hypertrophic or keloid)	❑ Yes	❑ No	Rash	❑ Yes	❑ No
Sensitive Skin	❑ Yes	❑ No	Changing Mole(s) - Color, Size, Bleeding	❑ Yes	❑ No
Hair Loss	❑ Yes	❑ No	Nail Changes	❑ Yes	❑ No
Growth(s)	❑ Yes	❑ No	Cold Sores	❑ Yes	❑ No
Dry Skin	❑ Yes	❑ No	Immunosuppression	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No	Injection Site Reaction	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Stents	❑ Yes	❑ No
Fever or Chills	❑ Yes	❑ No	Night Sweats	❑ Yes	❑ No
Unintentional Weight Loss	❑ Yes	❑ No	Fatigue	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No	Sore Throat	❑ Yes	❑ No
Nose Bleeds	❑ Yes	❑ No	Blurry Vision	❑ Yes	❑ No
Dry / Itchy Eyes	❑ Yes	❑ No	Abdominal Pain	❑ Yes	❑ No
Bloody Stool	❑ Yes	❑ No	GI Upset with Antibiotics	❑ Yes	❑ No
Nausea / Vomiting	❑ Yes	❑ No	Diarrhea / Constipation	❑ Yes	❑ No
Acid Reflux	❑ Yes	❑ No	Bloody Urine	❑ Yes	❑ No
Joint Aches	❑ Yes	❑ No	Muscle Weakness	❑ Yes	❑ No
Neck Stiffness	❑ Yes	❑ No	Headaches	❑ Yes	❑ No

Seizures	❑ Yes ❑ No	Dizziness	❑ Yes ❑ No
Cough	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Wheezing	❑ Yes ❑ No	Anxiety	❑ Yes ❑ No
Depression	❑ Yes ❑ No	Recent Stress	❑ Yes ❑ No
Hepatitis C	❑ Yes ❑ No	Lupus	❑ Yes ❑ No
Liver Disease	❑ Yes ❑ No	Herpes	❑ Yes ❑ No
HIV / AIDS	❑ Yes ❑ No		

Personal Habits

Please answer yes or no to the following:

Do you tan in a tanning salon? ❑ Yes ❑ No Do you use sunscreen ❑ Yes ❑ No

If Yes, what SPF?

Do you smoke or have you smoked in the past?

Year Quit

Do you have a history of drug use?

❑ Yes
❑ No

Have you received your flu shot?

If No, do you plan on getting vaccinated this flu season?

If you are 65 or older, Have you received the pneumonia vaccine?

Do you have a Living Will?

Do you have a Healthcare Proxy?

If Yes, Who?

Do you have an Advanced Directive?

Which statement(s) best reflects your wishes on advanced care recommendations?

❑ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

❑ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

❑ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Notice of Privacy Practices

DELMARVA DERMATOLOGY, LLC

_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone, email, text, or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of 10/01/2018 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer @302-402-3015 for more information, in person or in writing.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

DELMARVA DERMATOLOGY, LLC

I am a patient of DELMARVA DERMATOLOGY. I hereby acknowledge receipt of DELMARVA DERMATOLOGY's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of DELMARVA DERMATOLOGY 's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

Delmarva Dermatology LLC

DmvDerm.com

PATIENT NAME: _____

OFFICE POLICIES

ASSIGNMENT OF BENEFITS:

I hereby authorize the physicians and staff of Delmarva Dermatology, LLC, to render treatment to me or my dependents. I further authorize Delmarva Dermatology to release my personal health information for purposes of treatment, payment or operations by phone, mail, fax, or electronically. I assign and authorize payment of medical or surgical benefits directly to Delmarva Dermatology, LLC. I understand that any unpaid balances or non-covered balances will be my responsibility. I also understand that I will be charged a $35 returned check fee for any and all returned checks. We accept cash, checks, MasterCard, Visa, American Express and Discover as forms of payment.

Medical Photographs:

I understand that photographs may be taken of my body and/or skin condition for inclusion in my medical record.

SKIN TAGS:
Skin tags are considered “cosmetic” and therefore are not a covered service by the insurance company. There will be a fee associated with the removal of skin tags. It is at the provider’s sole discretion to determine if the skin tag can be submitted to the insurance company for any medical reasons.

COPAYS:
Copays are due at the time of service.
By my signature, I acknowledge that I have read and understand the above-referenced information.

_____
Signature of Patient or Responsible Party (if patient is a minor)

Date:_____

Jennifer Z. Cooper, M.D., FAAD, FACMS
Jillian Mudry, APRN, FNP-C

96 Atlantic Avenue • Suite 103 • Ocean View, DE 19970
302-402-3015 Fax- 302-402-5942