

Thi T. Tran, DO, FAOCD, FAAD
Board Certified Dermatology
Board Certified Mohs Micrographic Surgery



Skin Cancer and Mohs Surgery Specialist

Dear New Patient:

Welcome to Village Dermatology & Cosmetic Surgery! We are pleased that you have chosen us to care for your dermatologic needs. Our goal is to provide you with compassionate, accessible and quality dermatologic care for your skin, hair, and nails. Dr. Tran specializes in derma-surgery and the diagnosis and treatment of skin cancer.

Your skin care is important to us and Dr. Tran will take his time to address your concerns both medically and surgically. Each member of our staff is dedicated to making your visit a positive and educational experience. However, emergencies and unexpected delays during patient care may occur. We will do our best to minimize such delays. Thank you very much for your understanding and patience.

Please help us to provide you with the best of care by taking the time to review and complete the enclosed new patient forms.

Once you have completed the above forms, **please send the forms back by mail, drop them off at our office or bring them with you on your first visit.** In addition, Village Dermatology & Cosmetic Surgery is requiring all patients to bring 2 forms of identification: please bring your (1) **STATE/GOVERNMENT ISSUED DRIVER'S LICENSE** or **NON-DRIVER IDENTIFICATION CARD** and (2) **CURRENT INSURANCE CARD(S)**.

Should you have any questions regarding the enclosed forms, please do not hesitate to call us. We look forward to seeing you in our office so that we can get to know you better.

Your appointment date and time: _____.

Note: When you come for your appointment, please do not wear any fragrances such as perfume, lotion, or aftershave.

Thank you.

Sincerely,

Dr. Thi Tran and Staff

1950 Laurel Manor Drive, Suite 224 | The Villages, FL 32162 | tel 352.751.6565 | fax 352.205.7777

www.villagederm.com

Revision: 11/2016

VILLAGE DERMATOLOGY AND COSMETIC SURGERY, L.L.C.

***** PLEASE FILL OUT THIS FORM AS COMPLETELY AND ACCURATELY AS POSSIBLE*****

Please refrain from wearing perfume after-shave and strong-smelling lotions to the office. People who have allergies and illnesses, especially those undergoing chemotherapy, cannot tolerate strong scents. A number of patients have complained of sneezing, itchy and teary eyes and having to change seats due to heavy perfume scents

NP ___ CONSULT ___ DATE _____ TIME _____

Patient's Full Name: _____

Marital Status: S ___ M ___ W ___ D ___ Social Security # _____

Date of Birth: _____ Age: _____ Sex: F ___ M ___

Driver's License # _____ Issuing State: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Alternate Address: _____

City: _____ State: _____ Zip: _____

To respect your privacy please tell us which of the following numbers we should call to communicate with you regarding **APPOINTMENT REMINDERS, LAB RESULTS**, etc. **Only** list the phone number, or numbers, you want us to call.

Home Phone # _____ Work Phone # _____

Cell (Alternate) Phone # _____ Email: _____

Please list any family members or any other person that the staff can communicate with regarding your medical or insurance issues.

Name: _____ Phone #: _____

Occupation: _____ Employer _____

Employer's Address: _____

Spouse's name: _____ Spouse phone # _____

Person to contact in case of an emergency: _____

Emergency contact phone # _____

Your referring physician: _____ Phone # _____

Your primary care physician: _____ Phone # _____

Verified by (Initials)/Date: _____ / _____

MRN: _____

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Primary Insurance _____

Insured: (SUBSCRIBER) _____

Insured's relationship to patient: _____

Insured's Date of Birth: _____

POLICY # _____

GROUP # _____

Secondary Insurance _____

Insured: (SUBSCRIBER) _____

Insured's relationship to patient: _____

Insured's Date of Birth: _____

POLICY # _____

GROUP # _____

.....
_____ **Initial:** I authorize **Village Dermatology & Cosmetic Surgery, L.L.C.** to bill my insurance.

_____ **Initial: Authorization to release information:** I hereby authorize **Village Dermatology & Cosmetic Surgery, L.L.C.** to release any information required in the course of my examination or treatment, which could include pictures, HIV, communicable disease, drug abuse information or a letter regarding the care I have received with **Village Dermatology & Cosmetic Surgery, L.L.C.** to any of my referring doctors listed on **page 1.**

_____ **Initial: Authorization to pay:** I hereby authorize payment directly to **Village Dermatology & Cosmetic Surgery, L.L.C.** for the surgical and/or medical benefits, if any, otherwise payable to be for services.

I understand that I am financially responsible for the charges not covered by my insurance.

Patient Signature: _____ **Date:** _____

Verified by (Initials)/Date: _____ / _____

MRN: _____

BILLING PROCEDURE STATEMENT

Patient Name: _____

Date of Birth: _____

Thank you for choosing Village Dermatology & Cosmetic Surgery, LLC for your healthcare needs. Along with providing you with quality service, Village Dermatology would also like to assist you with your billing questions and needs. Please read the following provisions and initial the billing class that best represents you:

1. **Medicare only** – Village Dermatology & Cosmetic Surgery, LLC will file Medicare for you. Village Dermatology & Cosmetic Surgery, LLC accepts assignment; however, you will still be responsible for the 20% that Medicare does not cover at the time services are rendered.
2. **Medicare & Supplement** - Village Dermatology & Cosmetic Surgery, LLC will file both insurances for you. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days.
3. **Medicare Advantage/Complete Plan** – Village Dermatology & Cosmetic Surgery, LLC will file insurance for you. However, claims denied or rejected will be your responsibility in 30 days.
4. **BC/BS – PPO Only** - Village Dermatology & Cosmetic Surgery, LLC will file insurance for you. However, claims denied or rejected will be your responsibility in 30 days.
5. **Private Healthcare Insurance** – Full payment is due at the time services are rendered unless prior arrangements have been made. Village Dermatology & Cosmetic Surgery, LLC will provide you with an invoice for services rendered during your healthcare visit so that you may submit to your healthcare insurance company for reimbursement.
6. **Self-Pay** – Full payment is due at the time services are rendered unless prior arrangements have been made. Village Dermatology & Cosmetic Surgery, LLC will provide you with an invoice for services rendered during your healthcare visit.

I have been informed and understand the billing procedures of Village Dermatology & Cosmetic Surgery, LLC. I agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.

I also understand that all laboratory charges are billed separately from the physician's office services and are my responsibility to pay.

Signature of the patient OR legal representative and relationship to patient

Date

Verified by (Initials)/Date: _____/_____

MRN: _____

PATIENT NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **Date of Birth:** _____

This notice describes how medical information about you may be disclosed. Please review it carefully. Village Dermatology & Cosmetic Surgery, LLC will use your medical information for the following:

1. **TREATMENT:** Including providing your medical records to consulting clinicians and insurance companies.
2. **PAYMENT:** We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3. **HEALTHCARE OPERATIONS:** Any others involved in your healthcare.

The entire PRIVATE POLICY NOTICE of Village Dermatology & Cosmetic Surgery, LLC is posted in the waiting room for your perusal.

In conjunction with these privacy practices you will need to provide us with the following information:

1. Name of person(s) and telephone number(s) who we may speak to in regards to your healthcare (i.e. spouse, family member, etc.).

2. May we communicate with you by mail or leave a message on your answering machine in regards to your healthcare or an upcoming appointment? YES _____ NO _____

INFORMED CONSENT

I understand that during my course of treatment, unforeseen conditions may occur that necessitates a skin biopsy(s) to be taken by shave, punch, and/or excision. In addition, I also give permission to have minor surgical procedures and any subsequent treatments as deemed necessary as long as the risks and complications are discussed with me prior to the said procedure. These risks include, but are not limited to scarring, bleeding, swelling, pain, deformity, infection, and/or ulceration. I will also inform the practitioner of any possible contradictions to the planned procedure, including medications, such as anticoagulants, aspirin, cardiac, infections or psychotropic.

I recognize that every surgical procedure involves uncertainty and no result can be guaranteed. I also recognize that the practitioner is not responsible for natural complication that may occur. If any postoperative complications occur, it is my responsibility to contact the practitioner as soon as possible.

To document and follow the course of my treatment, I give permission to have photographs taken. Photographs are part of my medical record and confidential in nature. I also grant permission for the judicious use for medical education purposes if my identity is withheld.

I also consent to the disposal of any tissue, which is removed in accordance with accustomed practice and procedure. I give my permission to have any tissue removed during the procedure sent for histologic examination.

I understand that any controversy or claim arising out of medical care provided will be resolved through mandatory binding arbitration under the rules of the Florida Arbitration Code.

I have been informed and understand both the patient notice of privacy practices and informed consent listed above by Village Dermatology & Cosmetic Surgery, LLC.

Signature of the patient **OR** legal representative and relationship to patient

Date

Verified by (Initials)/Date: _____ / _____

MRN: _____

HISTORY (Medical, Social, Family) AND MEDICATION

Patient Name: _____

Date of Birth: _____

Have you in the past or present had:

1. Heart Disease, such as:

- Heart attack Y N
- Dates: _____
- Angina/Chest Pain Y N
- Abnormal rhythm Y N
- Coronary disease Y N
- High blood pressure Y N
- Heart failure Y N
- Pacemaker Y N
- Implantable Defibrillator Y N
- Heart valve Y N

2. Lung Disease, such as:

- Asthma/wheezing Y N
- Emphysema Y N
- Bronchitis Y N
- Chronic cough Y N
- History of TB (self) Y N
- History of TB (family) Y N
- Shortness of breath Y N
- Sleep Apnea Y N

3. Genital/Urinary:

- Kidney/Renal disease Y N
- Dialysis Y N
- Last date of dialysis _____

4. Skin:

- Basal Cell Nevus Syndrome Y N
- Chronic Scar Y N
- Squamous Cell Carcinoma Y N
- Basal Cell Carcinoma Y N
- History of Melanoma (self) Y N
- History of Melanoma (family) Y N
- History of Sun Exposure Or Sun Burns Y N
- Tanning Bed Use Y N
- Sunscreen/Sun block Use Y N
- Self Skin Exams Y N

5. Joints:

Patient interviewed: in person by phone **Date:** _____

Prosthesis Y N

6. Reproductive

Are you or might you be pregnant? Y N

7. Gastro intestinal:

- Liver disease Y N
- Jaundice Y N
- Hiatal hernia/Reflux Y N

8. Blood & Coagulation:

- AIDS/HIV Y N
- Hepatitis/type _____ Y N
- If yes, what type? _____

Anemia Y N

Problems bleeding after surgical procedure Y N

9. Nervous System:

- Strokes Y N
- Seizures/Epilepsy Y N
- Head/Neck injury Y N

10. Endocrine:

- Diabetes Y N
- Insulin Y N
- Thyroid disease Y N

11. Smoker

Stop Smoking Counseling Y N

Pkg/day _____

of years _____

12. Alcohol

Qty./Frequency _____

13. Have you or anyone in your family had high fever/complications during or after surgery? Y N

If yes, reaction: _____

14. Other:

- Arsenic Exposure Y N
- Immunosuppression Y N

15. Previous Surgeries/Other Medical Problems

Dentures upper lower none

Contact Lenses Y N

Drug allergies/reactions: _____

Allergic to local anesthetics Y N

Allergic to topical antibiotics Y N

Allergic to latex Y N

Sensitive to tape/bandages Y N

Blood thinning agents Y N

Vitamins/Herbal treatments

- Vitamin E
- Multivitamin
- Ginko
- Garlic tablet
- Other _____
- None

PLEASE LIST ALL MEDICATIONS, DOSES AND FREQUENCY ON THE NEXT PAGE (MEDICATION LIST).

Do you take NSAIDS? Y N

- Self prescribed
- Dr. prescribed

Do you take aspirin? Y N

- Self prescribed
- Dr. prescribed

Doctor _____

Why? _____

NURSE'S NOTES:

Reviewed

Nurse's/MA's signature/Date: _____

Provider's signature/Date: _____

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MEDICATION LIST

Patient Name: _____

Date of Birth: _____

Please PRINT clearly.

| Medication Name (Inc. OTC and Supplements) | Dosage | Frequency (i.e. Once a day) | How You Take/Use The Medication (i.e. Orally) |
|---|--------|--------------------------------|---|
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IMMUNIZATION RECORD:

Pneumonia Vaccine: Yes No Date of Last Dose: _____

Flu Vaccine: Yes No Date of Last Dose: _____

CURRENT PHARMACY:

Pharmacy Name: _____ Location: _____

Phone Number: _____ Fax Number: _____

Incomplete Record

_____ Patient is unable to provide some/all of the following information: dosage, frequency, and/or route of administration.

Patient Certification

I hereby certify that all information listed above and/or attached to this form is correct and provided to the best of my knowledge.

Signature of the patient OR legal representative and relationship to patient

Date

Verified by (Initials)/Date: _____ / _____

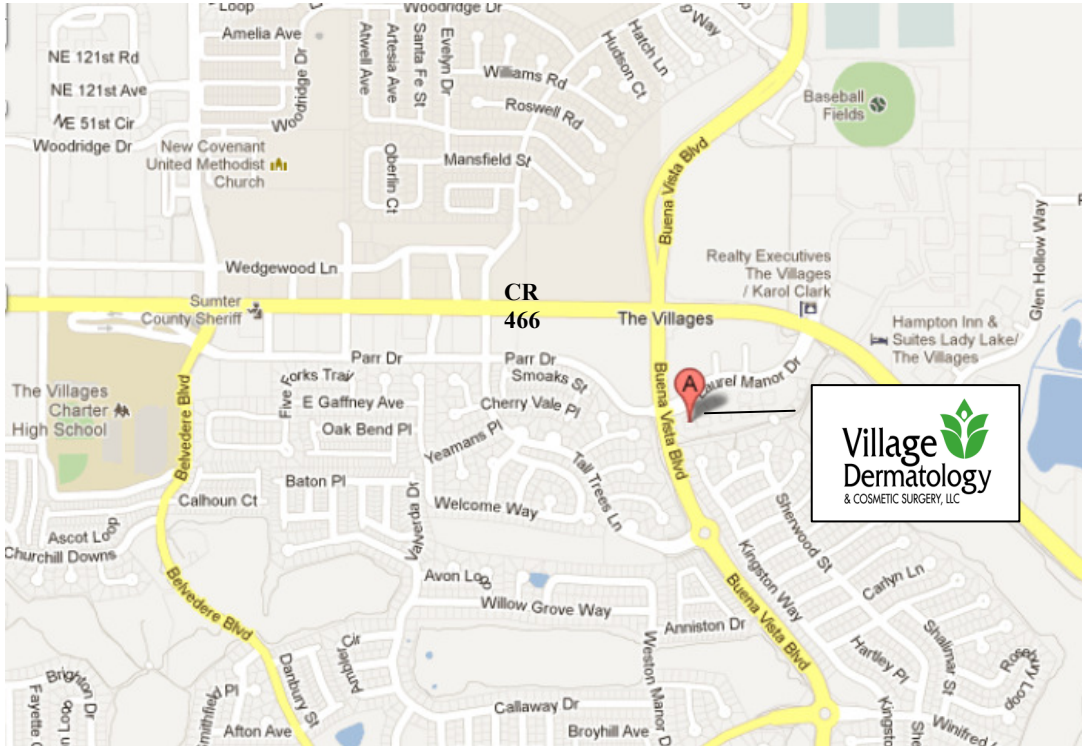
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DIRECTIONS TO VILLAGE DERMATOLOGY & COSMETIC SURGERY, LLC



From I-75

Take Wildwood Exit (#329) East on Hwy 44. At US 301, head North (left). Follow US 301 North for approximately 8 miles (through Wildwood). At CR 466, turn right into the Villages. Follow CR 466 for approximately 2 miles to Buena Vista Boulevard. Turn right on to Buena Vista Boulevard. Make the first left off of Buena Vista into the Laurel Manor Professional Park. Village Dermatology & Cosmetic Surgery, LLC is on the first right in Building 220, Suite 224.

From Ocala/Bellevue/Summerfield

Head South on US 301. At CR 466, head East (left) in to the Villages. Follow CR 466 for approximately 2 miles to Buena Vista Boulevard. Turn right (traffic light) on to Buena Vista Boulevard. Make the first left off of Buena Vista into the Laurel Manor Professional Park. Village Dermatology & Cosmetic Surgery, LLC is on the first right in Building 220, Suite 224.

From Leesburg/Fruitland Park

Head north on US 27. At CR 466, head West (left) in to the Villages. Follow CR 466 to Buena Vista Boulevard. Turn left (traffic light) on to Buena Vista Boulevard. Make the first left off of Buena Vista into the Laurel Manor Professional Park. Village Dermatology & Cosmetic Surgery, LLC is on the first right in Building 220, Suite 224.