

**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](http://www.villagederm.com)

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## 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 due to non-coverage 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 due to non-coverage will be your responsibility in 30 days.
5. **Private Healthcare Insurance (In-Network)** – Village Dermatology & Cosmetic Surgery, LLC will file insurance for you. However, claims denied due to non-coverage will be your responsibility in 30 days.
6. **Private Healthcare Insurance (Out-of-Network)** – 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.
7. **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

- 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**  Y  N  
 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? \_\_\_\_\_

**5. Joints:**

**Patient interviewed:**  in person  by phone **Date:** \_\_\_\_\_

**NURSE'S NOTES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Reviewed**

**Nurse's/MA's signature/Date:** \_\_\_\_\_

**Provider's signature/Date:** \_\_\_\_\_

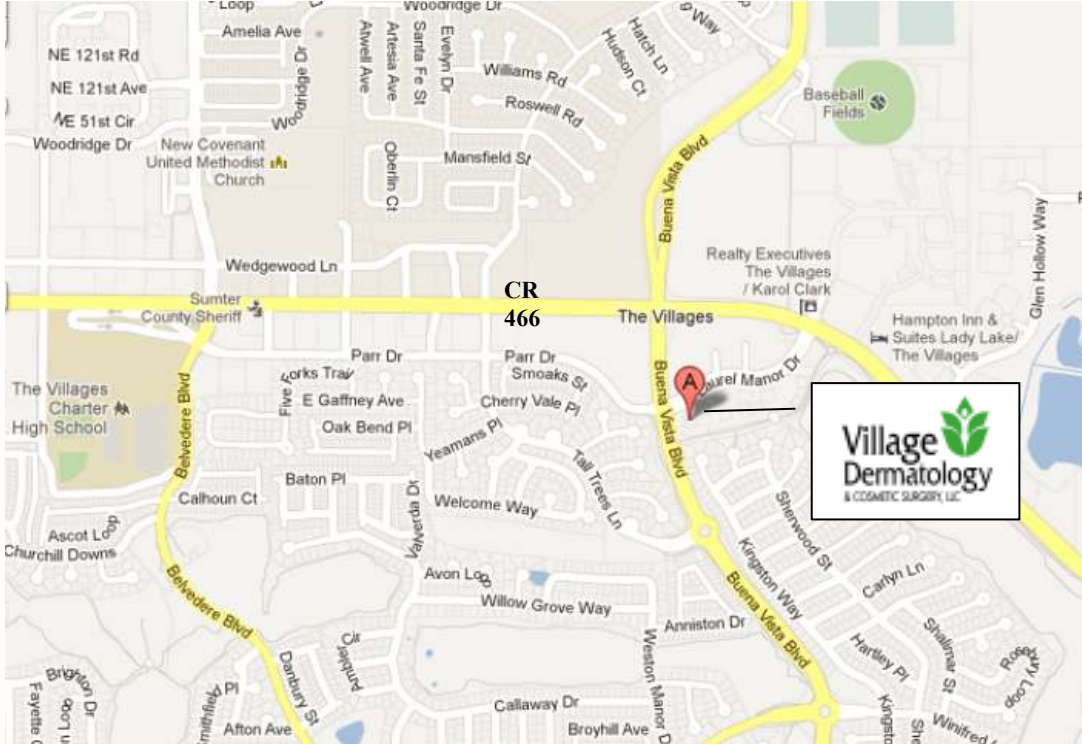


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## **DIRECTIONS TO VILLAGE DERMATOLOGY & COSMETIC SURGERY, LLC**



### **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/Belleview/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.