Blacksburg Office
2617 Sheffield Dr.
Blacksburg, VA 24060
Phone: (540) 953-2210
Fax: (540) 951-9112

____

Name Appointment Date/Time **(Please arrive 15 minutes early)**

Thank you for choosing New River Dermatology for your Mohs Micrographic Surgery. New River Dermatology is committed to providing you with the highest quality healthcare.
Please review and complete the attached forms and bring them with you to your appointment along with your insurance cards. If you have any questions, please do not hesitate to call our office at **(540) 953-2210 Monday through Thursday from 8:30 AM to 5:00 PM and Friday from 8:30 AM to 3:00 PM** and we would be happy to assist you. We look forward to seeing you at your appointment.
To prepare for your appointment, please read the Mohs Micrographic Surgery Brochure. There you will find detailed information about New River Dermatology and your upcoming procedure. It is recommended that you bring someone with you the day of your procedure. **Please continue any medications that you take on a daily basis, unless otherwise instructed. This includes any physician prescribed aspirin, Coumadin, Warfarin, Plavix and all similar drugs. Bring a detailed list of medications to your appointment. Include the medication name, dosage and frequency taken for all prescribed, over the counter and supplements.** Have a light breakfast/lunch since your appointment may last several hours.

Preparing for your appointment:

- FORM B – PACEMAKER/DEFIBRILLATOR or COCHLEAR IMPLANT
  - Please call (540) 953-2210 as soon as possible and provide the information if applicable.
- COMPLETE FORMS C, D & F AND BRING THEM WITH YOU TO YOUR APPOINTMENT
- READ FORM E – INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY – DO NOT SIGN
- REVIEW, SIGN & BRING THE INSURANCE BENEFIT VERIFICATION FORM TO YOUR APPOINTMENT
  - If you have any questions related to the Financial Policy of New River Dermatology, please call our Insurance Department at (540) 953-2210.
- POWER OF ATTORNEY, ADVANCE DIRECTIVE and DNR: If there is a Medical Power of Attorney, Advance Directive or DNR, a hard copy will need to be presented at the time of the appointment. If the Power of Attorney is in effect, whoever holds the Medical Power of Attorney should be present at your appointment.
- For more information, call Jennifer at (540) 953-2210. **Remember, at this time, Mohs surgery is only performed at the Blacksburg office.**

IF YOU HAVE AN EXISTING CANCER POLICY, IN ADDITION TO YOUR MEDICAL INSURANCE, OR IF YOU WOULD LIKE YOUR RECORDS SENT TO A DOCTOR OTHER THAN WHO REFERRED YOU, PLEASE REQUEST TO FILL OUT A MEDICAL RELEASE OF RECORDS FORM THE DAY OF YOUR APPOINTMENT. TO PROTECT YOUR HEALTH INFOMRATION, NO RECORDS WILL BE RELEASED WITHOUT A SIGNED RELEASE FORM. BEGINNING NOVEMBER 1, 2015, A $15.00 FEE WILL BE ASSESSED FOR CANCER POLICY RECORDS REQUESTS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE AT (540) 953-2210.

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FORM B

ATTENTION!!

** PATIENTS THAT HAVE UNDERGONE CHEMOTHERAPY OR A BLOOD/PLATELET TRANSFUSION IN THE PAST 6 MONTHS, WE MUST SPEAK TO YOU AS SOON AS POSSIBLE. **

Please call Jennifer at (540) 953-2210

PATIENTS WITH A PACEMAKER/DEFIBRILLATOR OR COCHLEAR IMPLANT

Please call Jennifer at (540) 953-2210 to provide the following information. This can be found on the wallet ID card given to you by your cardiologist:

- Manufacturer
- Model number
- Serial number
- Implant date
- Current cardiologist's name and phone number

Thank you in advance for helping us to give you the best medical care possible!

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Patient Registration

FORM C

Name: ____ Title: Mr. Mrs. Miss Ms. Dr.

First Middle Last

Mailing/Billing Address: ____

Street # Street Name Apt #

____

City State Zip Code

Home Phone: (____)________________ Work Phone: (____)_________________ Cell Phone: (____)_________________

Circle the Preferred Phone Number to contact you: H W C Email: ____

Date of Birth: ____/____/______ Sex: M F Social Security #: ____________________ Student: Full Time Part Time

____

Employer Name Address Phone

Are you a resident of a Skilled Nursing Facility? Yes No or Hospice? Yes No

If married, Spouse's **Name: ___________________________________ Spouse's **Date of Birth: ______/_______/_______

(**This information is required if your insurance policy is in your spouse's name)

How did you hear about New River Dermatology? ____

FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES FOR SERVICES COVERED BY INSURANCE. INSURANCE COVERAGE WILL BE PREVERIFIED AND YOU WILL BE RESPONSIBLE FOR ANY UNMET DEDUCTIBLE, COINSURANCE AND/OR COPAYMENTS. COSMETIC PATIENTS MUST PAY IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes New River Dermatology to release such medical information necessary to your primary care or referring physician, to consultants if needed and to the insurance company(s) listed below in order to process your insurance claim (if any). You herein authorize payment of medical benefits to New River Dermatology when an assigned claim is filed to the following insurance company(s):

Primary Insurance: _________________________________ Secondary Insurance: _________________________________

Name of policy holder if other than patient: ____

Social Security # of policy holder: _______________________________ Date of birth of policy holder: _____/______/_______

Patient Relationship to policy holder: Spouse Child Other

Signature of Patient or Legal Guardian ____ Date ____________________

IMPORTANT INFORMATION FOR NEW PATIENTS

Federal Law requires all healthcare practices to obtain, verify and record information that identifies each patient.

What this means for you: When you arrive at New River Dermatology, we will ask to see a photo ID issued by a local, state or federal government agency such as a drivers license, passport or military ID. If you do not have a government issued photo ID, please bring two forms of non-photo ID such as a Social Security Card, school or company ID or a utility bill with your name and address visible. Please contact New River Dermatology prior to your appointment if you do not have available forms of identification. You may reach us at (540) 953-2210.

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Patient History Form

Patient Name: ______________________________________ Patient Date of Birth: _____________________

I. Chief Complaint

Reason for your visit / Present Illness Comments ____

Who is your referring doctor? ____

	Yes	No	Manufacturer	Model/Serial Number	Implant Date	Notes
Pacemaker						
Defibrillator						
Cochlear Implant						
Other						

Do you have any of the following implants?

***Have you undergone chemotherapy or a blood/platelet transfusion in the past 6 months? Yes No**

II. Medications

List any current medications, vitamins and supplements. Please use a separate sheet of paper if necessary.

Drug	Dosage	Frequency

☐ **I am currently not taking any medications, vitamins or supplements.**

III. Local Pharmacy Information

Local Pharmacy Name	
Pharmacy Address	
Pharmacy Phone Number	

IV. Medication Allergies

Medication Allergy	Reaction	Medication Allergy	Reaction
1.		4.	
2.		5.	
3.		6.	

☐ **I have no known medication allergies.**

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Patient History Form

Patient Name: ____ Patient Date of Birth: ______________________

V. Past Medical History

Do You Have a History of Any of the Following?

	YES	NO
I HAVE NO PAST MEDICAL PROBLEMS.		
Abdominal Bleeding		
Arsenic Exposure (worked in tobacco fields)		
Artificial Joints/Heart Valve		
Asthma		
Bleeding Disorders/Problems		
Breast Cancer		
Cancer		
Chest Pain/Tightness		
Cognitive Impairment/Dementia		
Diabetes		
Fever Blister		
Glaucoma		
Heart Disease/Cardiac Stents		
Heart Murmur		
Hepatitis		
High Blood Pressure		
Immune System Problems		
Kidney Stones		
Lung Disease		

	YES	NO
Lymph Node Removal		
Organ Transplant		
Psychiatric Disease		
Radiation Therapy		
Rheumatic Fever		
Seizures		
Stroke		
Substance Abuse/Addiction		
Thyroid Disorder		
Tuberculosis		
SKIN HISTORY	**YES**	**NO**
Actinic Keratosis		
Basal Cell Carcinoma		
Dysplastic Nevus (abnormal moles)		
Melanoma		
Skin Disease		
Skin Cancer		
Squamous Cell Carcinoma		
PRE-OPERATIVE ANTIBIOTICS	**YES**	**NO**
Required prior to dental/surgical procedures?		

Please list any other past medical problems: ____

____

____

____

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Patient History Form

Patient Name: ______________________________________ Patient Date of Birth: _____________________

VI. Past Surgeries and/or Hospitalizations

Operations	Date	Notes	Anesthesia Problems?

☐ **I have no past surgeries and/or hospitalizations.**

VII. Social History

Alcohol	**YES**	
Denies alcohol use		
Admits alcohol use daily		
Admits alcohol use socially		
Tobacco Use	**YES**	
Denies smoking		
Used to smoke		
Admits to smoking cigarettes		Circle most appropriate: 1 pack/day or less More than 1 pack/day
Admits to smoking cigars/pipe		
Admits to chew/snuff		
Unable to assess		

VIII. Ability to Heal

	YES	NO
Does your skin appear fragile, bruise easily?		
Do you form thick or raised scarring from a cut or burn?		
Do you ever get cold sores?		

IX. Family History

Do You Have a Family History of Any of the Following?

	YES	Afflicted Family Member(s)		YES	Afflicted Family Member(s)
I **do not** have any family medical history of the following illnesses.			Cancer		
Adopted			Diabetes		
Abnormal Bleeding			Heart Disease		
Abnormal Clotting			High Blood Pressure		
Anesthesia Problems			Skin Cancer		

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Patient History Form

Patient Name: ____ Patient Date of Birth: ______________________

X. Review of Systems

Have You Experienced Any of the Following Symptoms Within the Last 6-8 Weeks?

Symptom	YES	NO
ALLERGIC/IMMUNOLOGIC		
Allergy to lidocaine or numbing medications		
Arthritis/joint deformity		
CARDIOVASCULAR		
Chest pain		
Heart attack		
Abnormal leg swelling		
CONSTITUTIONAL SYMPTOMS		
Fainting		
Fever or chills		
Unexpected weight loss or gain		
DERMATOLOGIC		
New skin growth/bumps		
Changing skin lesions or moles		
Lesions to lips/cold sores		
GASTROINTESTINAL		
Abdominal pain		
Nausea, vomiting, diarrhea		
Ulcers		

Symptom	YES	NO
GENITOURINARY		
Currently breast feeding		
Currently pregnant		
Kidney problems		
HEMATOLOGIC/LYMPHATIC		
Anemia		
Enlarged lymph nodes		
NEUROLOGICAL		
Muscle weakness		
Paralysis		
Numbness or tingling		
Headache		
RESPIRATORY		
Cough		
Shortness of breath		
Wheezing		
PSYCHIATRIC		
Depression		
Anxiety		
Other psychiatric disorder		

Explain below if you answered yes above:____

____

____

____

____

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INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY

Patient Name: ______________________________________ Patient Date of Birth: _____________________

This form is designed to provide you with the necessary information that you will need to make an informed decision on whether or not you wish to have Mohs surgery performed. All of the information provided in this form will be or has been reviewed with you by the physician. If you have any questions, please do not hesitate to ask us. Do not sign this form until you are instructed to do so.

WHAT ARE THE POTENTIAL COMPLICATIONS AND SIDE EFFECTS OF SKIN SURGERY?

1. **PAIN**: Some mild discomfort is experienced when the area is first anesthetized with the numbing medication. You may experience some mild discomfort during the procedure if the numbing medication has worn off in a particular location. This is easily remedied by immediately giving more anesthetic in that area. After the procedure some discomfort will be experienced at the surgical site. This is easily controlled with pain medications for a few days.
2. **INFECTION**: Any time that the skin is injured an infection is possible. The rate of infection is very low. Some patients will receive postoperative antibiotics to prevent an infection. If you feel that your wound is infected after surgery, please call our office immediately.
3. **BLEEDING**: When you leave our office, you will have a pressure bandage applied to your wound. Bleeding is always possible after surgery. Most cases of postoperative bleeding are easily stopped by applying pressure for 20 minutes over the site. If this does not work, please call our office immediately.
4. **SWELLING**: After surgery, you should expect some swelling where your surgery was performed and around the wound as well.
5. **HEMATOMA**: A hematoma is a collection of blood that forms under the skin. This results from bleeding that occurs after the surgery. A “lump” forms under the skin, which represents the dried blood. If this occurs, call our office immediately.
6. **SCAR FORMATION**: Any time that the skin is injured a scar will form. Some scars are more noticeable than others, but a scar is always present. A scar will form after your surgery. Hypertrophic and keloidal scarring are possible. If you have a history of bad scarring, please advise us at the time of your visit. The cosmetic appearance following the surgery is unpredictable.
7. **WOUND DEHISCENCE**: This means that your wound has broken back open after it has been repaired with sutures. It is very important to take it easy after your surgery so that unnecessary strain is not placed on the wound. This is an uncommon complication.

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INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY

8. **FAILURE OF FLAP OR SKIN GRAFT**: After your surgery is completed, we will need to repair the wound. Some patients are repaired with either a flap or skin graft. A flap is when skin is borrowed from a nearby site to close the defect. A skin graft is when a piece of skin is taken from one site and transplanted to another. A possible complication is the failure of either of these to take at the new site. Smoking is a documented risk for this complication. If you are a smoker, it is recommended that you discontinue smoking for two weeks before and after the procedure.
9. **TEMPORARY OR PERMANENT NERVE DAMAGE**: The primary goal of your surgery is to completely remove the tumor. In order to accomplish this, it is sometimes necessary to damage a nerve. Nerve damage can be temporary or permanent. Recovery usually takes 6 months or more and rarely can require additional surgery. Nerve damage may be limited to a loss of sensation or may include paralysis.
10. **DISTORTION/ALTERATION OF SURROUNDING ANATOMIC FEATURES**: The repair of healing of surgical wounds may distort the appearance of adjacent structures. Our goal is to completely remove your skin cancer and then concern ourselves with the function and appearance of surrounding anatomic structures.
11. **TUMOR RECURRENCE**: No skin cancer treatment has a guaranteed 100% cure rate. However, Mohs surgery has been shown to have the highest cure rate for the treatment of skin cancer.

** The complications of surgery are not limited to the above list **

- I acknowledge that I have received and read a copy of the Mohs Micrographic Surgery Brochure from New River Dermatology. This brochure fully explained to me the procedure and what to expect during and after the procedure. I understand its contents and all of my questions regarding the procedure have been answered. ____________ (initials)
- I acknowledge that I have read the entire consent form. I understand its contents and the doctor and/or his associate has adequately informed me of the risks, benefits, advantages, disadvantages, alternatives and possible complications of skin surgery. I also understand that the postoperative size of the surgical wound after removing the skin cancer and the method of repair cannot be predicted in advance and I could require a referral for additional closure or revision of the procedure site.
- I further request the administration of such analgesia and/or sedative medication as deemed necessary or desirable for the completion of the procedure. I understand that the administration of medication carries risks separate and apart from the risks of the procedure.
- I recognize that the results from the practice of medicine and surgery are not absolutely predictable and I acknowledge that no guarantees or assurances have or can be made concerning the results of such treatment. I further acknowledge that there have specifically been no guarantees as to the cosmetic results from the procedure.

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INFORMED CONSENT: MOHS MICROGRAPHIC SURGERY

All of my questions and concerns have been answered and I hereby consent to Mohs surgery and repair if necessary to be performed by Dr. Daniel Hurd and/or his associates upon ___________________________.
(Patient name)

I have identified and confirmed the location(s) of my surgical site(s). ___________
(initials)

- I also consent to the taking of photographs before, during and after the procedure. I understand that these photographs are important to document and follow my progress after surgery. These photographs will belong to New River Dermatology and may be used for research, educational and scientific purposes. This may include presentation at lectures or publication in medical journals. In such an event, I will not be identified by name. I expect no compensation for any such use of these photographs and I waive all my rights to any claims for payment or royalties. I also release Dr. Daniel Hurd and/or his associates/assistants from any liability in connection with the use of such photographs.
- I agree that any tissue removed during the course of the operation may be examined, documented, preserved and/or disposed of in a manner considered proper for diagnosis, study and advancement of medical knowledge.
- I understand that New River Dermatology has recommended that a spouse, relative or friend accompany me to New River Dermatology and drive me home following my surgery. If I decide to drive myself home, I understand and assume the risk involved
- I further consent that in the event of an emergency and I am transferred from New River Dermatology to another facility, I request that any and all documents pertaining to my care at the receiving facility be sent to New River Dermatology following my treatment at that facility.

Comments: ____
____
____

Date: ___________________ Time: _________________ AM/PM

________________________________	________________________________	____________________
Patient's Printed Name (or guardian/next of kin)	**Signature**	**Relationship** (if other than patient)

Patient's Date of Birth _______________________

I confirm that this form has been completely reviewed with the patient. The potential risks, side effects and complications were all discussed. All of the patient's questions have been answered.

________________________________	________________________________	____________________
Physician's Signature	**Witness Signature**	**Date**