

2020 VBF Vascular Birthmarks / Anomalies Conference & Clinic Mail-in Registration Form



Thank you for your interest in the 2020 VBF Vascular Birthmarks / Anomalies Conference & Clinic! The fastest way to register for this conference is on our website at <https://birthmark.org/conference>. Alternatively, you can fill out this form and mail it in to us at PO Box 106, Latham, NY 12110, along with a check for \$100.00 and a clear picture of the patient's birthmark.

Part 1: Registration Contact Information

First Name: _____ Last Name: _____

Email Address: _____ Phone: _____

Street Address: _____

City: _____ State/Province: _____ Postal Code: _____

Country: _____

Part 2: Registrant Details

- I am at least 18 years of age.
- I consent to my picture being taken and used by VBF.
- I need the US Embassy to issue a Visa.
- Please add me to the VBF Mailing list.

What is your relationship to the patient? _____

Please let us know of any dietary restrictions, if any. _____

Part 3: Patient Information

Please tell us about the patient attending the conference.

First Name: _____ Last Name: _____

Nick Name: _____ Patient Gender: _____

The patient consents to their photo being taken and used by VBF.

The patient needs daycare.

What will the patient's age be at the time of the conference? _____

Does the patient have any dietary restrictions? _____

What type of birthmark(s) does the patient have?

Infantile Hemangioma

Vascular Malformation

Arteriovenous Malformation

Venous Malformation

Lymphatic Malformation

CM /PWS – Capillary Malformation / Port Wine Stain Birthmark

Uncertain

Choose the patient's birthmark syndrome, if applicable:

Sturge-Weber Syndrome

PHACES

CLOVES

Klippel-Trenaunay Syndrome

CMTC

Other/Unknown

Who is the patient's current physician? (List up to 3)

1. _____
2. _____
3. _____

Please describe where the birthmark is located and be sure provide a photo clearly showing the patient's birthmark so that we can best tailor our conference services for you.

Please check all that apply:

- I wish to apply for a free hotel room based on economic need.
- I'm interested in a free laser therapy session on Friday, September 25. (NOTE: current patients of Dr. Geronemus are ineligible)
- I'm interested in a free psychotherapy session.
- I'm interested in a free professional make-up session. (NOTE: make-up sessions are reserved for patients only) 6/11
- I'm interested in a free dental exam.
- I'm interested in a free orthodontic exam.
- I'm interested in a free insurance consultation.

Do you have any scheduling conflicts (flights, etc.)?

Are there any other preferences you wish us to take into account?

Part 4: Additional Attendees

Please give us the information of up to 3 maximum additional attendees.

Additional Attendee #1:

First Name: _____ Last Name: _____

Dietary Restrictions (if any): _____

Over 18

If not over 18, age at the time of the conference: _____

Needs Daycare

Additional Attendee #2:

First Name: _____ Last Name: _____

Dietary Restrictions (if any): _____

Over 18

If not over 18, age at the time of the conference: _____

Needs Daycare

Additional Attendee #3:

First Name: _____ Last Name: _____

Dietary Restrictions (if any): _____

Over 18

If not over 18, age at the time of the conference: _____

Needs Daycare

Part 5: Billing Information

First Name: _____ Last Name: _____

Email Address: _____ Phone: _____

Street Address: _____

City: _____ State/Province: _____ Postal Code: _____

Country: _____

Please choose your billing amount:

- \$100 – all inclusive conference / clinic fee
- \$25 – I am requesting a waiver of the conference / clinic fee so that I will only pay a mandatory \$25 processing fee.

Please choose your payment method:

- I am enclosing a check for the amount above.
- Please bill my credit card for the amount above.

Card Number: _____

Expiration Month/ Year: _____ CVC: _____

Note: By sending us this document, you are verifying that you have read our HIPAA policies at <https://birthmark.org/hipaa-notice-of-information-practices-and-privacy-statement/>.