Vascular Birthmarks Foundation 2023 Annual Conference and Clinic Registration October 6-8, New York City

We look forward to welcoming you to the 2023 VBF Annual Conference and Clinic in New York City! The quickest way to register is on our website. Alternatively, you can complete this form and mail it to PO Box 106, Latham, NY, 12110, along with your fee payment and a clear photo of the patient's birthmark. You can email any questions to Chris at chris@birthmark.org.

To register for the Clinic, we require some information about the registrant, the patient, the patient's birthmark (including a required photo showing the birthmark), your preferences for services and sessions, and any other people in your group who may be attending, such as another parent.

Registrant Contact Information: *The registrant is the parent, guardian, or spouse of the patient with a birthmark or the adult with a birthmark.*

First Name: _____ Last Name: _____

Email: _____ Phone: _____

Street Address: _____ City: _____

State/Province/Region: _____ ZIP/Postal Code: _____

Country: _____

Registrant Details:

Please tell us some more information about the Registrant:

☐Yes ☐No Are you at least 18 years old?

☐Yes ☐No Do you consent to your picture being taken and used by VBF?

☐Yes ☐No Do you need the US Embassy to issue a visa? *Please note, due to COVID-19, we are unable to assist in securing a visa to the US. If you need a visa, please contact your embassy to find out requirements.*

☐Yes ☐No Do you want to be added to the VBF mailing list?

What is your relationship to the patient? ☐Self ☐Parent ☐Sibling ☐Other

How did you hear about VBF? ☐Website ☐Dr. Linda ☐Google ☐Friend or Relative
☐Physician or Nurse ☐Social Media ☐Other _____

Patient Information: *Please tell us about the patient who will be attending the Clinic.*

First Name: _____ Last Name: _____

Nick Name: _____Patient Birth Date: _____

Patient Gender: ☐Male ☐Female ☐Prefer not to answer

Does the patient consent to their picture being taken and used by VBF? ☐Yes ☐No

Patient Birthmark Information:

Please tell us about the patient's birthmark so we can provide the most appropriate services:

☐Infantile Hemangioma

☐Congenital Hemangioma

☐Port Wine Stain (capillary malformation)

☐Venous Malformation

☐Lymphatic Malformation

☐Arteriovenous Malformation

☐CMTC

☐Other/Unknown

Please tell us about the patient's birthmark syndrome, if applicable:

☐Sturge-Weber Syndrome

☐Klippel-Trenaunay Syndrome (KTS)

☐PHACE Syndrome

☐CLOVES Syndrome

☐Other, Unknown

Who are the patient's current physicians? (add up to 3 names)

Physician #1_____

Physician #2_____

Physician #3_____

Please describe where on the body the birthmark is located: _____

_____

_____

Birthmark Photo:
Please provide a photo clearly showing the patient's birthmark so that we can best tailor our Clinic services for you. **A photo is required** and is necessary to assign you to the appropriate clinical teams. Include the photo with this registration form, or email the photo to info@birthmark.org. Accepted file types: jpg, gif, png, jpeg, (less than 5 MB). *When emailing, please include the patient's name in the subject line for filing purposes.*

Services and Sessions:

Please let us know which services and sessions you are interested in:

☐ Yes, I wish to apply for a free hotel room based on economic need for Friday night.

☐ Yes, I'm interested in a free laser therapy session on Friday. *(Note: Current patients of Dr. Nelson are ineligible.)*

☐ Yes, I'm interested in a free dental exam on Friday. *(Note: This is for patients with facial birthmarks.)*

☐ Yes, I'm interested in a free orthodontic exam on Friday. *(Note: This is for patients with facial birthmarks.)*

☐ Yes, I'm interested in a free ultrasound appointment on Friday.

☐ Yes, I'm interested in a free consultation appointment on Saturday.

☐ Yes, I'm interested in a free psychotherapy session on Saturday.

Patients with VBARS involving the mouth:

What are your primary orthodontic/dental concerns to address at the Super Clinic? Check all that apply:

☐ Oral bleeding issues

☐ Tissue overgrowth

☐ Teeth development

☐ Decay

☐ Candidate for orthodonture

☐ Safe oral care and intervention

Additional Attendee:

Do you want to add another attendee? In addition to the registrant and the patient, you can add up to one additional attendee, such as another parent, if applicable.

First Name: _____ Last Name:_____

Relationship to Patient: _____

Please let us know of any scheduling conflicts or other preferences you want us to take into account:

_____

_____

Billing Information:

☐ Same as Registrant Contact Information

First Name: _____ Last Name:_____

Email: _____ Phone: _____

Street Address: _____ City: _____

State/Province/Region: _____ ZIP/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.

Credit Card #: _____

Expiration Month/Year: _____ CVC: _____

If you need to cancel for any reason before the deadline, we will issue you a full or partial refund of your registration fee, upon request.

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