Dermatology of Boca
Jeffrey S. Fromowitz M.D., F.A.A.D.

NEW PATIENT REGISTRATION

NAME: ______________________ **Date of Birth:** ____/____/______ **Social Security #:** ________________
MM / DD / YYYY

ADDRESS: ______________________ **CITY:** ______________________ **STATE:** ______ **ZIP:** __________

GENDER: ________ **Home Phone #:**______________ **Cell#**______________ **Work Phone #:**______________

OCCUPATION:______________________________ **EMPLOYER:**______________________________

EMERGENCY CONTACT: ______________________ **RELATION:** ____________ **Phone #** ________________

NORTHERN ADDRESS: ______________________ **CITY:** ________________ **STATE:** ____ **ZIP:**________

EMAIL:__________________________ **RACE:**____________________ **ETHNICITY:**________________

WHOM MAY WE THANK FOR YOUR REFERRAL: ____

ALL PATIENTS PLEASE COMPLETE AND SIGN BELOW

INSURANCE COMPANY__________________________ID#__________________________________

MEDICARE: ____________ MEDICARE ID NUMBER: ______________________________________

I

I authorize any holder of medical information to release any information that is required by my insurance company. As the responsible party, I agree that all charges incurred by me or my dependents for services rendered by the Dr (except those paid directly by Medicare) are my financial responsibility. All court fees, attorneys fees or other fees necessary to collect this account are payable by me. In the event of litigation arising from any medical services received at any time I agree to binding arbitration and waive any other rights.

SIGNATURE: ____ DATE: ________________

MEDICARE PATIENTS ONLY, PLEASE READ AND SIGN BELOW

We are participating physicians and will file your claim for you. Today you will be responsible for "your part" which is 20% (unless you have an approved supplemental policy) plus your unmet deductible for the current year. I request that payment of authorized MEDICARE benefits be made on my behalf to the Dr. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I have not pledged or assigned my benefits to any Health Maintenance Organization (H.M.O.).

SIGNATURE: ____ DATE: ________________

MEDICARE PATIENTS WITH SUPPLEMENTAL COVERAGE, PLEASE READ AND SIGN BELOW

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me.

SIGNATURE: ____ DATE: ________________

SUPPLEMENTAL INSURANCE COMPANY NAME:__________________________________

SUPPLEMENTAL POLICY NUMBER: ____

ALL PATIENTS PLEASE READ AND SIGN. I UNDERSTAND THAT ALL SPECIMENS (BIOPSIES AND CULTURES) WILL BE SENT TO AND BILLED BY AN INDEPENDENT LAB.

SIGNATURE: ____ DATE: ________________

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

______	ALLERGIES (Please List Below*)	______	GLAUCOMA
______	STOMACH ULCER	______	HIGH BLOOD PRESSURE
______	PACEMAKER	______	TB/LUNG DISEASE
______	PROSTATE PROBLEMS	______	CANCER
______	HEART DISEASE	______	ECZEMA
______	ASTHMA	______	GLANDULAR/HORMONAL DISEASE
______	ARTHRITIS	______	BLEEDING DISORDER
______	SEIZURES	______	KIDNEY DISEASE
______	COLITIS	______	INFLUENZA VACCINE
______	LIVER DISEASE	______	PNEUMONIA VACCINE
______	AIDS/HIV	______	FAMILY HISTORY OF SKIN CANCER
______	DIABETES	______	#OF ALCOHOLIC DRINKS WEEKLY
______	DO YOU SMOKE?	______	I REQUEST A FULL BODY EXAM

PLEASE LIST ANY and ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

ASPIRIN? ________________________ COUMADIN? __________________________

ANY BLOOD THINNERS? ____

ALL OTHER MEDICATIONS:

____

*IF YOU HAVE ANY ALLERGIES, PLEASE LIST THEM: _________________________________

ARE YOU PREGNANT/BREAST FEEDING? _________IF YOU BECOME PREGNANT PLEASE ADVISE THIS OFFICE.

HAVE YOU BEEN ADVISED TO TAKE ANTIBIOTICS BEFORE SURGICAL PROCEDURES? ________

FAMILY DOCTOR: ___________________________ PHONE: _______-______-__________

REFERRING DOCTOR: ______________________________PHONE: _______-______-_________

DO YOU HAVE AN ADVANCE CARE PLAN (LIVING WILL/SURROGATE)? YES or NO (Please Circle)

IF YES, WHAT IS THE FULL NAME?:____

4601 N Federal Highway
Boca Raton, FL 33431
561-362-8000

Federal Regulations regarding your PROTECTED HEALTH INFORMATION

With my consent, Dermatology of Boca may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology of Boca's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Dermatology of Boca may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including results among others.

With my consent, Dermatology of Boca may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as reminder cards and patient statements.

By signing this form, I am consenting to Dermatology of Boca's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology of Boca may decline to provide treatment to me.

_______I have received a copy of Dermatology of Boca's Notice of Privacy Practices.

_______I have been offered a copy of Dermatology of Boca's Notice of Privacy Practices but do not want a copy.

____

_______________________________________ _________________________
Signature of Patient or Legal Guardian **Date**

_______________________________________ _________________________
Patient's Name PRINTED **Date of Birth**

CONSENT FOR OPERATIONS AND SPECIAL PROCEDURES

Patient Name:____ Date:____________

1) I hereby authorize Dr. Jeffrey Fromowitz and/or Stefanie Gold PA-C to perform upon the above patient, the operation and/or procedures know as:

Biopsy **Excision** **Cryotherapy**

2) If any unforeseen conditions arise during the course of operation, I do hereby authorize the Doctor and his Physician's Assistant and/or Medical Assistants to take whatever steps, and to perform whatever procedures they deem advisable which may be in addition to, or different from those now planned.

3) Dr Fromowitz and/or staff have explained to me the general method of procedure, and he/she also explained to me that there are always certain risks and consequences that are associated with the aforesaid procedure and he/she explained the risks and consequences of the procedure. These, among others, are scarring, pigmentary changes to the skin, reoccurrence of skin cancer or other lesion, problem, and possible damage to blood-vessels, or parts next to them such as nerves, infection, or allergic reactions or heart, brain, kidney, liver, lung complications, and very rarely, even death.

4) The alternatives to the operation and/or procedures have been fully explained to me and I was told that one alternative was that I could refuse the operation or procedure.

5) I acknowledge that no guarantee or assurance has been made to me as to any of the results or risks, and I assume such risk, and that the practice of medicine is not an exact science, and I understand these facts.

6) **I DO NOT** want to have further explanation, discussion, or description of the risk involved in all of these procedures.

7) I consent to the disposal by the above named physician any tissue parts which mat be removed from me. I understand that this tissue will be sent for pathologic evaluation and that I will be financially responsible for all the charges related to this evaluation regardless of the reimbursement from my insurance carrier. I also understand that I will not hold Dermatology of Boca professionally or personally responsible for the pathologic interpretation of said tissue and that this tissue may be sent for additional tests or evaluation at my or my insurance company's expenses.

8) I consent to the taking of photographs in the course of this operation for the purpose of advancing medical education, as may be authorized by my physician, and to admittance of qualified observers to the operation room, as determined by the physician/surgeon.

9) FOR PATIENTS UNDERGOING SKIN CANCER TREATMENT: I understand that I have skin cancer and that it is my responsibility to seek follow- up care by my dermatologist every three (3) months. Failure to seek follow-up care is my responsibility and I do not hold Dr. Fromowitz or Dermatology of Boca personally or professionally responsible for the skin cancer follow-up.

I have read the above, I understand the words, and agree to the terms:

________________________________ ________________________________
(Patient or Guardian / relationship) (Witness)

I have explained the matters indicated above relating to the operation and/or procedure and the risks, consequences, and alternatives. The patient and/or guardian verbalized and understanding and consented to the procedures described above

____
(Physician/ PA-C)

PHARMACY INFORMATION

We will need your Pharmacy information to call in your prescriptions. You must already be registered with your Pharmacy to have prescriptions called in. Thank you.

____

PRIMARY PHARMACY NAME

____

PHARMACY ADDRESS

____

PHARMACY PHONE NUMBER

____

SECONDARY PHARMACY NAME

____

PHARMACY ADDRESS

____

PHARMACY PHONE NUMBER