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)

AGREEMENT TERMS

Patient Name:_____

I agree to allow the practice to charge my credit card for the balance due, as determined by the final adjudication, of any insurance claim resulting from providing dermatology services for the above patient.

Visa / Master Card / Amex (circle one) Exp Date: __ __ / __ __
Account number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below. I agree to these charges under the following conditions:

- Any charges to the card will take place within 90 days of the final explanation of benefits from the patient's insurance company.
- The amount charged to my card will not exceed $250.00 for any one claim.
- I will receive a bill from the practice for any balance greater than $250.00 for which the patient is liable.
- I will receive a receipt or notification for any amount charged to my card once the transaction has been executed.
- I can cancel this authorization at any time upon written notice to the practice which will take effect for any service provided subsequent to the receipt date of the notice. Any notice of cancellation is effective on the date it is actually received at the practice.
- I acknowledge that I am completing the agreement based on the promise that the money is available on my credit card. I intend to be legally bound by the terms of this agreement.

Cardholders Name: _____

Cardholders Signature: _____

Date: _____

Practice Signature: _____

Please contact us if any questions or concerns:

4601 North Federal Highway. Boca Raton. FL. 33431
Phone: 561-362-8000 Fax: 561-447-6806

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

Dermatology of Boca
Cosmetic Intake Form

Name: _____ Date: ___/___/____

DOB: ___/___/____ Email: _____

What services are you interested in learning about during your consultation?
(Please check all that apply)

- ☐ Skin Care Advise
- ☐ Skin Care Products
- ☐ Botox/Dysport
- ☐ Restylane/Juvederm/Perlane/Radiesse/Belotero
- ☐ Facial Lines/Wrinkles
- ☐ Sun Spots
- ☐ Broken Blood Vessels/Blotchy Skin
- ☐ Body Contouring
- ☐ Hair Removal
- ☐ Acne Scars
- ☐ Lengthening Eyelashes
- ☐ Laser
- ☐ Leg Veins
- ☐ Facial Veins
- ☐ Omnilux Light Treatment For: Acne, Rosacea or Sun damage
- ☐ Other (please explain) _____

What is your current skin care regimen? _____
_____

Is it okay to email you about upcoming office cosmetic promotions and events (your email will not be shared with any outside parties)? ☐ **Yes** ☐ **No**

Are you currently pregnant and/or breast feeding? ☐ **Yes** ☐ **No**

Do you take any of the following medications: Coumadin, Plavix, Pradaxa, Aspirin, or other medications that increase your risk for bleeding?
☐ **Yes** If yes, which one? _____
☐ **No**

Do you have a history of keloid type scarring? ☐ **Yes** ☐ **No**

Have you ever had any cosmetic procedures performed? ☐ **Yes** ☐ **No**
If yes, what type: _____
If yes, were you happy with the outcome? ☐ **Yes** ☐ **No**

Would you be interested is seeing our aesthetician to further discuss skin care services offered such as microdermabrasion, facials, peels, blackhead treatment, etc? ☐ **Yes** ☐ **No**