Patient Information

Last Name:_____ First:_____ Middle Initial:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone: _____

Social Security:_____ Driver's License: _____

Date of Birth:_____ Age:_____ Sex: F M Marital Status: S M D W Separated

Email:_____

Name of Spouse:_____ & Work Number: _____

Patient's Employment:

Employer:_____ Occupation:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number:_____ ext.:_____ Fax Number:_____

In Case of Emergency:

Name:_____ Relationship:_____ Phone No:_____

Responsible Party (Subscriber Information) if different from above:

Name:_____ Date of Birth: _____

Social Security/ID:_____ Relationship to Patient: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Number:_____ Work Number:_____

Family Physician:_____ **Phone No:**_____

Referred By: ( ) Ins Directory, ( ) Yellow Pages, ( ) Patient:_____, ( ) Physician:_____

Insurance: Medicare Supplement Private/Commercial:_____
Please give the front desk your card(s) with a picture ID so we may copy them for our records.

Is this medical condition due to an accident of any kind? ( ) YES ( ) NO
If yes: Work related ( ) Auto ( ) Injured at home ( ) Other:_____

Welcome to our office. We are here to serve your dermatological needs.

We will accept your insurancee after we have verified that you have satisfied your annual deductible and if the reason for your visit to the Doctor(s) is a covered Medical condition under your policy. I authorize and request my insurance company and/or government benefits to pay directly to Dr. Vitor Weinman and/or Dr. Dulce C. Cabrera for services furnished to me or my dependents by said physician/supplier. My signature authorizes the releasing of my medical information and/or of my dependents to the insurer or agency shown necessary to pay the "claim" – by paper or electronically. I permit a copy of this authorization to be used in place of the original. Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge; and the patient

is responsible only for the deductible, co-insurance and any non-covered services or services denied due to HMO enrollment (at the time services are rendered) determined by the carrier which we do not participate with.

I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the nature of the service be such that it is not covered by the policy, I will be responsible to the Doctor(s) for payment of the entire bill.

I agree that should this account be referred to any agency or attorney for collection, I will be responsible for all collection costs (up to 50% of balance), attorney's fees and court costs. I certify that the information given by me is correct. I have read and understand all of the above and have agreed to them.

_____ _____

Patient's Signature *Date*

Patient's Name:_____ **Acct No:**_____

Past Medical History:

Past Illnesses: Check (√) the illnesses that have occurred in the past

☐Respiratory ☐Tuberculosis ☐Chicken Pox ☐Measles ☐Mumps ☐Pneumonia ☐Liver ☐Heart ☐HBP ☐Kidneys

☐Migraines ☐Circulatory ☐Ulcers ☐Skin Cancer ☐Cancer ☐Diabetes ☐Stroke

Any Surgeries: _____Date:_____

_____Date:_____

Cosmetic Surgery: _____ Date:_____

_____ Date:_____

Family Medical History:

	√ If Alive	Age at Death	Present Health or Cause of Death		# Alive	# Deceased	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			

Present:

Do you Smoke Cigarettes_____ Cigars_____ Do you Drink Alcoholic Beverages_____ How Often_____

If Female, Are you pregnant?:_____ Do you take Oral Contraceptives? ☐YES ☐NO _____

Present Dermatological Problem:_____

Have you noticed any relationship between stress and your medical problem(s)?_____

Current Medical Condition: Check (√) your current medical condition(s):

☐Diabetes ☐Heart ☐High Blood Pressure ☐Emphysema ☐ Gout ☐Arthritis ☐ Asthma ☐Migraine ☐Epilepsy
☐Ulcers ☐Ears ☐Throat ☐Nose ☐Eyes ☐Liver ☐Psychiatric ☐Cancer ☐Circulatory ☐Immune Deficiency
☐Thyroid ☐Skin ☐Other:_____

Allergies: ☐Penicillin ☐Sulfa ☐Iodine ☐Aspirin ☐Anesthetics ☐Other:_____

Current Medications: _____

_____

Pharmacy:_____ Address:_____Phone:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent or Guardian Signature of Physician

_____ _____
Date Date

Today's Date_____

Vitor Weinman, MD - General and Cosmetic Surgery

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Patient's Name (PRINT):_____

Date of Birth: _____/_____/_____ Sex: M ☐ F ☐ Phone:_____

My appointment is with: ☐ Dr. Weinman ☐ Dr. Cabrera

We are in the process of implementing a Patient Portal to provide a communication option for our patients in compliance with Health and Human Service Requirements. Please provide a valid email address below: Please note after 10 days you may have access to your record, please login to the portal to review it:

(REQUIRED)_____@_____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Language Preference: ☐ English ☐ Spanish Other: _____

Race: ☐ Caucasian or European American ☐ African or African American ☐ Asian or Asian American
☐ Native American or Native Alaskan ☐ Native Hawaiian or Other Pacific Islander

Smoking Status:
☐ Not a current tobacco user
☐ 0 Cigarettes per day (non-smoker or less than 100 in lifetime)
☐ 0 Cigarettes per day (previous smoker)
☐ Current Tobacco User

Please select the option that best describes your tobacco use.
Few (1-3) cigarettes per day

☐ Up to 1 pack per day
☐ 1-2 packs per day
☐ 2 or more packs per day

Do you take any prescription or non-prescription medications? ☐ No ☐ Yes (If yes please list)
_____Dosage(s):_____
_____Dosage(s):_____
_____Dosage(s):_____

Allergies to Medications? ☐ No ☐ Yes (If yes please list)_____
Location: ☐ Skin ☐ Local ☐ Abdominal ☐ Systemic/Anaphylactic
Reaction: _____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Immunization for Pneumococcal Vaccine: ☐ No ☐ Yes If Yes, Administered on: _____

Please check if you have a history of the following:

☐ High Cholesterol	☐ Joint Replacement	☐ Cancer
☐ Depression	☐ High Blood Pressure	☐ Thyroid Condition
☐ Diabetes	☐ Skin Cancer	☐ Asthma

☐ Other_____

Signature:_____ Date: _____/_____/_____
(Parent or Guardian Signature if child is a minor)

Pharmacy Name_____ Address:_____ Phone Number_____

(Please allow 24 hours for prescriptions to be filled. Thank

Vitor F. Weinman, MD and
South Kendall Dermatology
Coral Gables: 305-445-2941
Kendall: 305-971-1210

Informed Patient Consent

Patient's Name:_____ Acct:_____

I give my permission for the Doctors and Staff of this practice to treat me, including any biopsy or procedure(s), as deemed necessary in the exercise of their professional judgment.

PLEASE INITIAL EACH LINE AND SIGN AT THE BOTTOM

_____ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes of demographics, insurance carrier or changes in my condition. If I need to cancel my appointment, I must do so with 24 hours notice. We have a $25.00 no show or cancellation fee.

_____ I authorize my physician and/or staff of this practice to take photographs of my lesions/growths as part of my medical record. I understand that the photographs may include appropriate portions of the body to demonstrate possible

surgery sites or procedures and that every effort will be made to protect the patient's identity in those materials and all obtained is the sole property of this practice.

_____ I understand I may be billed by an outside laboratory for blood work or pathology services or 2nd opinions that is performed in this office. If my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company, for any reasons including but not limited to deductibles, co-pays and co-insurances. It is my understanding that I must contact that laboratory to discuss my services or invoices.

_____ In the event that I chose to provide this practice with my email address, I hereby authorize this practice to contact me using the email address I provided for internal marketing, specials and billing/invoice purposes, and agree to allow this practice to continue to contact me using email until I advise in writing, that they can no longer contact me using email. In return for allowing this practice to contact me using email, this practice promises not to release, sell or otherwise distribute any email address I provided to any other person or entity without my express written authorization.

_____ I have read and understand the consent form that has been provided to me by my doctors and staff.

Patient's Signature: _____ Date:_____

My signature on this form authorizes the providers and staff of this practice to perform the following procedures, if necessary:

Shave Biopsy / Punch Biopsy / Shave Removal / Surgical Excision / Skin Tag Removal / Incision and Drainage
Cryotherapy / Intralesional Steroid Injections / Intramuscular Steroid Injections / Electrodessication

I have been informed, to my satisfaction, regarding the nature of the procedure and why it is necessary.
I have been informed, to my satisfaction, regarding the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia and the formation of thick or otherwise objectionable scars and I realize that such, or any, natural complications may result from the surgical procedure.
I give permission to have any tissue(s) removed during this procedure to be sent for histological examination by a pathologist.
I have been informed, to my satisfaction, regarding the risks inherent to the performance of the procedures such as pain, swelling, redness, blister formation, discoloration, thinning of the skin, atrophy, possible scarring and recurrence.

Patient's Signature:_____ Date:_____

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Vitor F Weinman, M.D. and Associates at 401 Miracle Mile, Suite 207, Coral Gables, Florida 33134.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the above mentioned address. You must provide us with a reason that supports your request.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer at (305) 445-2941. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

   If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at (305) 445-2941.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

Signature:_____

Date:_____

Name of Patient:_____

Date:_____

“WARNING”

The following is to inform you that all medications, whether tablets (oral) or creams (topical) taken must be stopped if pregnancy occurs or if you are planning a pregnancy.

Please advise your physician if the above applies to you.

“AVISO”

La siguiente es para informarle que todas las medicinas que usted esta tomando, sean tabletas o cremas deben ser descontinuadas si usted se embaraza o si esta planeando un embarazo.

Por favor notifique a su medico si lo previo se aplica a usted.

_____
Patient’s Name/ Nombre

_____
Signature/Firma