DERMATOLOGY ASSOCIATES
OF THE PALM BEACHES, PLLC

Patient Information Sheet

Please fill out the entire form. If a question does not pertain to you please write N/A (non-applicable).

Last Name _____ First Name _____ Patient ID # _____

DOB _____ Sex M / F SS# _____ Marital Status __ Married __ Single __

Divorced __ Widowed __ _____

Patient Guarantor Name _____Address_____

DOB_____ SS#_____

Home # _____ Cell #_____ Work _____

EMAIL _____ How do you wish to receive reminders?

__ Phone __ Mail __Email__Text

Is it OK to leave a detailed Message ? ___Yes ____No

Florida Address _____ City _____ State _____ Zip _____

Alternate Address _____ City _____ State _____ Zip _____

Employer _____ Employer Phone # _____

PCP (Primary Care Doctor) _____ City, State _____

Which doctor referred you here? _____ City, State _____

Pharmacy _____ City and cross streets _____ Pharmacy Phone # _____

Where did you hear about us: __ Radio __ TV __ Internet __ Paper __ _____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT. DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

Race : _____ Ethnicity : _____

__ American Indian/Alaska Native __ Nat. Hawaiian/Pacific Islander __ Declined
__ Asian __ Hispanic or Latino
__ Black/African American __ White __ Not Hispanic or Latino
__ Declined

Primary Language : _____

Do you understand English? __ Yes __ No Do you need communication/translation assistance? __ Yes __ No

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DERMATOLOGY ASSOCIATES OF THE PALM BEACHES

Financial & Office Policies

Thank you for choosing us as your health care provider. We care about our patient's physical and financial well being and welcome the opportunity to work with you on any billing issue that may arise. We have implemented a new financial and office policy stating our expectations and options for payment.

I assign all medical and/or surgery benefits, to include “major medical” benefits, which I am entitled inclusive of Medicare and all other health payments this association is entitled. Payment is due at the time services are provided unless other plan(s) have been set up. I understand you do not accept assignment in the case of liability actions.

Insurance Billing
Though Dermatology Associates of the Palm Beaches accepts most insurance plans, I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract. I agree to be responsible for all copay's, deductibles and non-covered services determined by my insurance plan.

Insurance Referrals
If my insurance plan requires a referral to a specialist, I understand that I must obtain that referral prior to my scheduled visit. If the referral is not obtained, I understand that I have the option of rescheduling my appointment or paying for the visit out of pocket.

Self Pay
If I am un-insured or do not have proof of insurance, I understand that full payment is expected at the time of service unless prior arrangements have been made.

Patient Billing
I understand that I will be sent a **single** monthly statement followed by a reminder letter for services received. I will promptly pay all amounts determined to be my responsibility by my insurance carrier upon receipt of my statement. If my account is not paid within 90 days of the date of service, the practice may ask for the assistance of an outside collection agency. **I will be responsible for any reasonable cost of collection including credit checks, court costs and attorney's fees.** If I have any questions regarding my bill or have a financial hardship, I will call the office to make other arrangements. I understand that if my check is returned, I will be charged a fee of $35.00.Special services not cancelled within 24 hrs prior to appointment. There will be a $50.00 charge.

I authorize the release of medical record information to: 1.) The above named insurance companies, 2.) any physician who has participated in my health care, and 3.) to any physician to whom I may subsequently be referred.

Co-payments are paid at the time of the visit. I am responsible to be knowledgeable of my insurance coverage, deductible, and co-pays for any services provided by Dermatology Associates of the Palm Beaches. I understand that I am financially responsible for payment of any services rendered to me by Dermatology Associates of the Palm Beaches. I have read and accept the terms of this policy.

Signature _____ **Date** _____

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MEDICAL HISTORY

PATIENT NAME: _____ DOB_____ DATE: _____

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

SKIN CANCER: BCC/SCC/MELANOMA
ANXIETY
ARTHRITIS
ASTHMA
ATRIAL FIBRILLATION (IRREGULAR HEARTBEAT)
STROKE
HEART ATTACK
BONE MARROW TRANSPLANTATION
BPH
BREAST CANCER
COLON CANCER
COPD
CORONARY ARTERY DISEASE
DEPRESSION
DIABETES
END STAGE RENAL DISEASE
GERD
HEARING LOSS
HEPATITIS
HYPERTENSION
HIV / AIDS
HYPERCHOLESTEROLEMIA
HYPOTHYROIDISM
HYPERTHYROIDISM
LEUKEMIA
LYMPHOMA
LUNG CANCER
LUPUS(systemic,discoid,etc)
PROSTATE CANCER
RADIATION TREATMENT
SEIZURES
HISTORY OF ORGAN TRANSPLANT
BLEEDING DISORDERS
IMMUNOSUPPRESSION
OTHER: _____

PAST MEDICAL SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

NONE
APPENDIX (APPENDECTOMY)
BLADDER (CYSTECTOMY)
BREAST BIOPSY
BREAST: LUMPECTOMY (L/R/BIL)
COLON (COLECTOMY):COLON CANCER RESECTION
COLON (COLECTOMY): DIVERTICULITIS
COLON: IBS/IBD
COLON : COLOSTOMY
GALLBLADDER (CHOLECYSTECTOMY)
HEART : BIOLOGICAL VALVE REPLACEMENT
HEART : CORONARY ARTERY BYPASS SURGERY
HEART : HEART TRANSPLANT
HEART : MECHANICAL VALVE REPLACEMENT
HEART : CARDIAC STENT
JOINT REPLACEMENT : HIP (L/R/BIL)
JOINT REPLACEMENT : KNEE (L/R/BIL)
KIDNEY : BIOPSY/STONE REMOVAL
KIDNEY : KIDNEY TRANSPLANT
KIDNEY : NEPHRECTOMY
LIVER : HEPATECTOMY
LIVER : LIVER TRANSPLANT
LIVER : SHUNT
OVARIES: ENDOMETRIOSIS/CANCER/CYST
OVARIES : TUBAL LIGATION
PANCREAS : PANCREATECTOMY
PROSTATE : PROSTATE BIOPSY
PROSTATE : PROSTATECTOMY
PROSTATE : TURP
RECTUM : LOW ANTERIOR RESECTION
SPLEEN (SPLENECTOMY)
TESTICLES (ORCHIECTOMY)
UTERUS (HYSTERECTOMY) : FIBROIDS/CANCER

OTHER: _____

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

OTHER: _____

Do you wear sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

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Do you have a family history of Melanoma? Yes No If yes, which relative? _____

MEDICATIONS: _____
_____
ALLERGIES:_____
_____
SOCIAL HISTORY:
SMOKING STATUS: CURRENT SMOKER FORMER SMOKER NEVER
ALCOHOL USE: OCCASIONALLY 1-3 PER DAY NONE
FAMILY HISTORY: (ONLY FIRST DEGREE RELATIVES)
_____
_____

PHARMACY: NAME _____ PHONE # _____ CITY OR ZIP _____

REVIEW OF SYSTEMS: CHECK YES OR NO IF CURRENTLY EXPERIENCING ANY OF THE FOLLOWING

	YES	NO
ABDOMINAL PAIN		
ANXIETY		
BLOODY STOOL		
BLURRY VISION		
CHANGES IN MOLES		
CHEST PAIN		
COUGH		
DEPRESSION		
FEVER OR CHILLS		
HEADACHES		
JOINT ACHES		
RASH		
SEIZURES		
SHORTNESS OF BREATH		
SORE THROAT		
THYROID PROBLEMS		
WHEEZING		

ALERTS: (PLEASE CIRCLE ALL THAT APPLY)
ALLERGY TO ADHESIVE
ALLERGY TO LIDOCAINE
ALLERGY TO TOPICAL ANTIBIOTIC OINTMENTS
ARTIFICIAL HEART VALVE
ARTIFICIAL JOINTS WITHIN THE PAST TWO YEARS
BLOOD THINNERS
DEFIBRILLATOR
MRSA
PREMEDICATION PRIOR TO PROCEDURES
RAPID HEARTBEAT WITH EPINEPHRINE
PLANNING PREGNANCY
PREGNANT
BREAST FEEDING
HEPATITIS
HIV/AIDS
DEMENTIA

PACEMAKER

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SIGNATURE _____
DATE _____

To Our Patients,
I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health care professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine health care operations such as assessing care quality and reviewing the competence of health care professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how health information may be used or disclosed to carry out treatment, payment or health care operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.
The physicians and staff of Dermatology Associates of the Palm Beaches respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.
___ I wish to be contacted by the telephone, FAX, and email I provide and it is OK to leave a detailed message on these. I also wish to permit Dermatology Associates to contact my listed emergency contacts and direct family relatives in the same way.
___ I wish to be contacted by my home and cell phone numbers only. It is OK to leave a detailed voice mail on those numbers.
___ I wish to be contacted by my home and cell phone numbers only. However, any voice mail may only have a message identifying Dermatology Associates is calling and I do not wish any medical information to be left on voice mail. I understand that this means that it will/might be more difficult for me to receive important medical information.
___ I give permission for photos to be taken of my skin. I understand that these photos will become a part of my medical chart.
___ I give permission for photos (without any identifying features) to be used for research, teaching, or marketing purposes.
___ Other _____

Name of person we can share information with	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Print Patient Name Date of Birth

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_____
_____
Patient Signature Date

Dermatology Associates of the Palm Beaches

This intake form is *required* information for Medicare compliance for *all* patients as we are Medicare providers. We apologize for any inconvenience.

Who is your primary care/referring provider? _____

Alcohol Use: Screening & Brief Counseling
How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Tobacco Use (Smoking cigarettes, cigars, or using tobacco of any form)

Check one:	Check one:
__ Current smoker	__ Heavy tobacco user
__ Former smoker	__ Light tobacco user
__ Never Smoked	

Influenza Vaccine
Check the one that best fits:
__ Received a flu vaccine this flu season.
__ Did not receive a flu vaccine this flu season, because of medical reasons.
__ Did not receive a flu vaccine this flu season, because I didn't want one.
__ Did not receive a flu vaccine this flu season.

Pneumococcal Vaccine (For patients 65 and older ONLY)
Check the one that best fits:
__ Received a pneumococcal vaccine (Pneumovax).
__ Did not receive a pneumococcal vaccine.

Advanced Directives
Advances directives are designed to respect your autonomy and determine your wishes about future life-sustaining medical treatment if you are unable to indicate your wishes. Key interventions and treatment decisions are: resuscitation procedures such as Cardiopulmonary Resuscitation (CPR), and mechanical respiration (breathing tube).

Which statement(s) **best reflects** your wishes on advanced care recommendations?
__ I want full cardiopulmonary resuscitation efforts to be made (**Full Code**).
__ I do not wish to have a breathing tube, even if it is necessary to save my life (**Do Not Intubate**).
__ If my heart were to stop, I do not wish to have chest compression or an automated external defibrillator to restart my heart, even if it's necessary to save my life (**Do Not Resuscitate**).
__ I have a living will.
__ I have a health care proxy whose name is _____, and contact information is _____.

_____

Patient Signature

Patient Extra Contact Information

I wish to allow Dermatology Associates, Inc. permission to contact these people as needed:

Spouse or Close Partner:

Contact Name: _____

Telephone #: _____

Other Emergency Contact:

Contact Name: _____

Telephone #: _____

Assisted Living/Caretaker/Nursing Home:

Contact Name: _____

Telephone #: _____

_____
Patient Name

_____ _____
Patient Signature Date