BREVARD MEDICAL DERMATOLOGY

Minor Patient Information

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ RACE/ETHNICITY: _____ ☐ MALE ☐ FEMALE

HOME ADDRESS: _____

EMERGENCY CONTACT NAME: _____

PHONE #: _____ RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

Parental Information

PARENT/LEGAL GUARDIAN NAME: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

HOME ADDRESS: _____

WHAT IS THE BEST WAY TO CONTACT YOU?: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ EMAIL ☐ MAIL

HOME PHONE #: _____ WORK PHONE #: _____

CELL PHONE #: _____ EMAIL: _____

PLEASE LET US KNOW IF YOU WISH TO OPT OUT OF APPOINTMENT REMINDERS SENT BY HOME PHONE (CALL), CELL PHONE (TEXT), OR EMAIL.

Insurance

PRIMARY INSURANCE: _____ POLICY ID #: _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____ DATE OF BIRTH: _____

Consent to Treat

I do hereby solemnly swear that I have legal custody of the aforementioned minor child. I authorize the release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits to be made directly to my child's doctor.

I authorize Brevard Medical Dermatology, PA and its staff to administer treatment to my minor child. I understand that if I allow my minor child to attend any subsequent appointments without me, they must be accompanied by a letter with a personal dated signature stating that they may receive treatment in the office of Brevard Medical Dermatology, PA without my being present.

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

BREVARD MEDICAL DERMATOLOGY

Patient Release of PHI

TODAY'S DATE: _____

Authorization for Disclosure

This form is for family and friends only. If the patient is a minor, please list both parents/legal guardians.

I (the patient) give authorization to the physicians and staff of Brevard Medical Dermatology, PA to release my protected health information to:

FULL NAME	RELATIONSHIP	PHONE #

I further understand this authorization will remain in effect unless terminated with a personal dated signature.

_____
SIGNATURE OF PATIENT

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN IF MINOR

Acknowledgement of HIPAA Notice of Privacy Practices

I have received a copy (let us know if you would like a copy) or have reviewed a copy (located in Lobby or at www.brevardmd.com) of Brevard Medical Dermatology's HIPAA Notice of Privacy Practices ("Notice"). The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be updated at any time. I may obtain a revised copy of the Notice by notifying the Privacy Officer at Brevard Medical Dermatology, PA.

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR) DATE

BREVARD MEDICAL DERMATOLOGY

Patient Past Medical History

Internal diseases and medication side effects can manifest themselves on the skin. Therefore, it is important for us in dermatology to know your other medical conditions, medications and allergies to medications. Please fill out this form to the best of your knowledge.

PATIENT NAME: _____ DATE OF BIRTH: _____

Preferred pharmacy name and location? _____
Do you have an Advanced Care Plan or Living Will? ☐ Yes ☐ No
Did a doctor recommend you see a dermatologist? ☐ Yes ☐ No Dr. _____

General Medical History

Check any of the following that apply and use the lines below for explanations:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation (irregular heart beat)
- ☐ Bone Marrow Transplant
- ☐ BPH (enlarged prostate gland)
- ☐ Breast Cancer (which breast?: _____)
- ☐ Colon Cancer
- ☐ COPD (lung disease)
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Flu Vaccine (date received: _____)
- ☐ GERD (gastroesophageal reflux disease)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker/Defibulator (circle one)
- ☐ Pneumonia Vaccine (date received: _____)
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Use this space for explanations AND other medical conditions (PLEASE PRINT):

_____

_____

Past Surgical History

List all past surgeries and dates (PLEASE PRINT):

_____ _____

_____ _____

Past Dermatologic History

Check any of the following that apply:

- ☐ Acne
- ☐ Actinic Keratosis (pre-cancerous growth)
- ☐ Asthma
- ☐ Basal Cell Carcinoma (type of skin cancer)
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Hay Fever/Allergies
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma (type of skin cancer)
- ☐ Poison Ivy
- ☐ Cancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma (type of skin cancer)

Do you wear sunscreen? ☐ No ☐ Yes, what SPF: _____
Do you tan in a tanning salon? ☐ No ☐ Yes, when last: _____

Family History

Is a blood relative affected by any of the following?
Skin Cancer:
☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Melanoma
Which relative: _____
Autoimmune Disorder:
☐ Lupus ☐ Psoriasis ☐ Rheumatoid Arthritis ☐ Thyroid Disease ☐ Other_____
Which relative: _____
☐ Adopted, family history unknown

Medications

Check any of the following that apply and use the lines for explanations:
☐ Aspirin (strength: _____)
☐ Coumadin/Warfarin
☐ Plavix
☐ Other blood thinners (list):

_____
_____

☐ Over-the-counter medications/supplements and dosage:

_____
_____
_____

☐ Other prescription medications (PRINT names):

NAME	DOSAGE	xDAILY

Allergies to Medications

Check the box if allergic AND list your reaction (PLEASE PRINT):
☐ Lidocaine ☐ Epinephrine ☐ Penicillin ☐ Betadine/Iodine ☐ Sulfa
Reaction: _____

☐ Codeine, Morphine, or Narcotics, Reaction:

_____
_____
_____

☐ Other Antibiotics, Name and Reaction:

_____
_____
_____

☐ Other Medications, Name and Reaction:

_____
_____
_____

☐ Creams/Ointments, Name and Reaction:

_____
_____
_____

Social History

Do/did you smoke? ☐ Never ☐ Yes, _____ packs/day Total Yrs Smoking?: _____ Start: _____ Quit: _____
Do you use alcohol? ☐ No ☐ Yes, _____ drinks/day
Do you use caffeine? ☐ No ☐ Yes, _____ cups/day

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF MINOR) DATE