Patient Name: _____ **DOB:** _____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

Please indicate with an X.

Personal History

_____ Reactions to local anesthetic: (Allergy, fainting, rapid heartbeat)
_____ History of cold intolerance (fingers turn white/blue; painful in cold)
_____ History of pre-cancer / actinic keratosis
_____ History of skin cancer
_____ History of melanoma
_____ History of treatment with Efudex/ Aldara/Solaraze/Liquid Nitrogen
_____ History of abnormal moles
_____ History of asthma / hay fever
_____ History of skin diseases (i.e. psoriasis eczema) Name: _____
_____ Tuberculosis
_____ Diabetes
_____ High Blood Pressure
_____ Nervous / Depression
_____ History of thick / bad scars

_____ HIV (+) / AIDS
_____ Hepatitis
_____ Heart Disease
_____ Heart Attack (Date: _____)
_____ Stroke (Date: _____)
_____ Circulatory problems/abnormal heart valve
_____ Immune Disease
Multiple Sclerosis / Rheumatoid Arthritis
Name: _____
_____ Blood disorders / excessive bleeding
_____ Liver Disease
_____ Renal Disease (kidney)
_____ Dialysis patient
_____ Ulcers
_____ Cancer (other than skin) _____
_____ Prostate Disease
_____ Glaucoma / cataract
_____ Thyroid Disease

Do you take antibiotics prior to Dental / Surgical procedures? _____ yes _____ no
Do you have any artificial joints / implants, pacemaker, or defibrillator? _____ yes _____ no
Are you pregnant or breast feeding? _____ yes _____ no

Family History

_____ Family history of melanoma
_____ Family history of skin diseases
Name of condition: _____

_____ Family history of Lupus, Scleroderma, Sarcoidosis
_____ Family history of asthma / hay fever

Please list your current medications (and Approximately how long you have been taking i.e. days, weeks, months, years)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergy to medications:

_____
_____
_____

Do you take any blood thinners?
aspirin / coumadin / ecotrin / plavix
vitamin e / ginko biloba / ticlid

Do you take any vitamins, supplements, herbal products?

_____
_____

"I understand the removal of a skin growth may leave a permanent scar."

_____ _____
Patient Signature **Date**

Patient Information

Patient Name _____ Sex _____ Date _____

Social Security # _____ Birthdate _____ Age _____ Race _____

Mailing Address _____ Phone _____

Street City Zip

Second Address _____ Phone _____

Street City Zip

Employer _____ Occupation _____ Day Phone _____

Spouse _____ Day Phone _____

Family Physician _____ Referring Physician _____

Primary Insurance Company _____

Name of Policy Holder _____ Birthdate _____

Patient Relationship to policy holder _____Self _____Spouse _____Child _____Other:_____

Secondary Ins Co _____ Name of Policy Holder_____ Birthdate _____

Patient Relationship to policy holder _____Self _____Spouse _____Child _____Other:_____

In order to establish the best relationship with our patients and avoid future misunderstandings regarding our payment policies, our staff is trained to inform you of our financial policies.

- **PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES**. We accept Visa, Mastercard, Discover and American Express for your convenience.
- As allowed under Florida state law, if you decide to request your records be sent to another office or for personal use there is a $1.00 charge for each page up to 25 pages/$.25 for each additional page.
- We charge a **NO SHOW** fee of $50 for all cosmetic injectable visits that you do not cancel or reschedule within 48 hours.

Your signature below indicates:

- You understand and accept the above policy regarding payment/records requests/no show appointments
- You authorize the doctor to release such medical information as is necessary to process your insurance claims (if any).
- You authorize payment of medical benefits to Florida Dermatology Associates, Inc. when an assigned claim is filed.

_____ _____

Signature of patient (parent or legal guardian if under 18) Date

Meaningful Use/MACRA is mandated for physicians by the federal government. The practice is penalized if you do not complete this form.

Name _____ Date _____

Email _____

Pharmacy Name	Address	City	Zip	Phone

Please Circle One:

Ethnicity:

Hispanic or Latino

Not Hispanic or Latino

Unknown

Race:

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

Caucasian

Unknown

Decline to specify

Preferred Language:

_____

Have you received a pneumonia vaccine?

Y N

Have you received a flu vaccine during flu season?

Y N

Have you had a one-time screening for the HEP C Virus?

Y N

Do you have a healthcare proxy?

Y N

Name:

_____

Phone #: _____

Do you have a living will?

Y N

Smoking Status (12 years and up):

Every day smoker

Current some day smoker

Former smoker

Never smoker

Florida Dermatology Associates
HIPAA Patient Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

1) Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

2) Please print the address **(if other than your home)** where you would like your billing statements and/or correspondence sent: _____

_____

3) Please print the phone number (if other than the number provided to us) where you want to receive calls about your appointments, lab result or other healthcare information. **We will not leave actual lab results on your phone. Please follow-up with us for results.**

_____

4) Can confidential messages (ie., appointment reminders) be left on your phone answering machine or voicemail? _____ Yes _____ No

5) **I understand the Privacy Protection Act and have been offered a copy of Florida Dermatology Associates, Inc. Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.**

_____ _____ _____
Printed Name – Patient Signature Date

_____ _____ _____
Printed Name -Guardian/Representative Signature Relationship To PT

_____ _____ _____
Witness-Printed Name-Practice Rep Signature Date