COASTAL DERMATOLOGY, PA

2804 ST. JOHNS BLUFF RD S, STE 109

JACKSONVILLE, FLORIDA 32246

PHONE: (904) 727-9123

FAX NO: (904) 855-4255

183 LANDRUM LANE STE 201

PONTE VEDRA BEACH, FL 32082

PHONE: (904) 567-1050

FAX NO: (904) 567-1051

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

PHARMACY:_____

APPROXIMATE HEIGHT_____WEIGHT_____

HAVE YOU HAD THE FLU VACCINE_____

HAVE YOU HAD THE PNEUMOCCAL VACCINE_____

HAVE YOU HAD THE SHINGRIX VACCINE_____

DO YOU SMOKE_____DRINK ALCOHOL_____

IF YES, HOW MANY DRINKS DAILY_____WEEKLY_____

HAVE YOU CONSUMED 5+ DRINKS IN ONE DAY IN THE PAST YEAR_____

DO YOU HAVE AN ADVANCE DIRECTIVE CARE PLAN____YES/NO

EMAIL ADDRESS:_____

PRIMARY CARE PHYSICIAN:_____

REFERRED BY:_____

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Welcome to our practice. Please complete the following forms. Please **PRINT** all information. Thank you.

PRIMARY LANGUAGE:_____ RACE:_____ETHNICITY:_____

PATIENT NAME:_____
(LAST) (FIRST) (MIDDLE INITIAL)

CHECK ONE: SEX M___F___ MARRIED:_____SINGLE:_____WIDOWED:_____DIVORCED:____

DATE OF BIRTH:_____ SOCIAL SECURITY NO:_____

PATIENTS ADDRESS:_____
STREET ADDRESS/APARTMENT NUMBER

_____
(CITY) (STATE) (ZIP)

HOME TELEPHONE NO:_____MOBILE PHONE NO:_____

EMPLOYED BY:_____OCCUPATION_____

BUSINESS ADDRESS:_____BUSINESS PHONE:_____

NAME & PHONE NUMBER OF EMERGENCY CONTACT:_____

IF UNDER 18, PARENT/GUARDIAN NAME AND PHONE NO:_____

EMAIL ADDRESS (FOR PATIENT PORTAL):_____

PRIMARY CARE PHYSICIAN:_____
NAME AND PHONE NUMBER

REFFERRED BY:_____PHARMACY NAME & NO:_____

INSURANCE INFORMATION

For your protection, patients(s) and/or legal guardian must provide a valid photo identifiction card along with appropriate Insurance cards. We bope you understand we cannot make exceptions.

_____*CHECK HERE IF YOU DO NOT HAVE INSURANCE OR DO NOT PLAN TO USE YOUR INSURANCE BENEFITS.*

PRIMARY INSURANCE_____POLICY ID:_____

GROUP#_____

ADDRESS:_____

POLICY HOLDER:_____RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BITH:_____SOC. SEC#_____

SECONDARY INSURANCE:_____POLICY ID:_____

ADDRESS:_____

POLICY HOLDER:_____RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BITH:_____SOC. SEC#_____

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MEDICAL HISTORY

1. Reason for today's visit:_____

_____

2. Medical History (Include any prior or current medical problems, serious illnesses or injuries, operations, skin problems or skin cancers.

_____

_____

3. Family History include any illnesses or diseases including skin problems or skin cancers.

_____

_____

4. Please list all medications including non prescription drugs that you take regularly:

_____

_____

5. Please list known drug allergies or reactions you may have bad to any medications:

_____

6. Please provide any additional information you feel may be helpful to us:

_____

7. Would you like information or any of the following?

_____Treatment of sun damaged skin
_____Improving skin texture and tone or removal of unwanted hair
_____Personalized skin care regiment/Physician Grade Products
_____Reduction of fine/deep lines & wrinkles
_____Botox
_____Fillers (Juvederm, Sculptra, Radiesse)
_____Physician grade facials or chemical peel
_____Vaser Liposelection (body contouring)
_____Acne Scarring
_____Lasers

_____ _____
Printed Name Date

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Acknowledgements/Authorizations:

- In the event that it is necessary to cancel or reschedule your appointment, we ask that you notify us at least 24 hours before your scheduled appointment. This allows us to make that time available for another patient. If we receive inadequate notice or you miss the appointment, you may be charged a missed exam/surgery fee.

- If a personal or business check is issued by you or at your behalf is returned unpaid for any reason by the financial institution, an additional fee as determined by vendor policy or Florida Statute will be added to the amount owed. **STATEMENT OF FINANCIAL RESPONSIBILITY**

- I acknowledge I am financially responsible for all charges for services provided to me, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, an HMO or any other payer. I also acknowledge that if I fail to pay for services provided and not paid by any health care plan(s), my account may be forwarded for collection and I will also be responsible for any collection related charges and that information will be reported to credit reporting agencies Additionally, 1 acknowledge Coastal Dermatology will not submit claims to my heat insurance carrier for services deemed cosmetic.

- I authorize Coastal Dermatology, PA to relcase all medical information necessary to all insurance carriers or any other payers; person(s) I have designated as guarantor for the billing, payment and coverage for my account any other health care providers for treatment purposes.

- I authorize my insurance carrier, health plan administrator or any other payer to pay directly to Coastal Dermatology any benefits due under the terms of my health care plan(s) for services provided by same. I understand Coastal Dermatology reserves the right to refuse or accept assignment of medical benefits. If my plan will not allow direct payınent to Coastal Dermatology or if she provider chooses not to accept assignment, I agree to immediately forward all health care payments I receive for those services provided by Coastal Dermatology, I authorize Coastal Dermatology to contact my insuance carrier, health plan administrator, other payer or review agencies to obtain all pertinent benefit and financial information concerning corverage and payments made under my health plan. I further authorize my insurance carrier, health plan administrator, and any other payer, agents or review agencies to release such information to Coastal Dermatology.

_____ _____

Patient/Guarantor Signature Date

_____

Printed Name

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Attention Patients!!! We are updating our method of contact for your appointment reminders, we are now sending text message and email reminders for up-coming appointments!! Please provide your most current cell phone number and e-mail address

Thank you,

Coastal Dermatology

PATIENT NAME AND DOB:_____

PLEASE CHECK ONE:

☐ **I WOULD LIKE TEXT MESSAGE REMINDERS.**

CELL PHONE #_____

☐ **I WOULD LIKE EMAIL REMINDERS.**

EMAIL ADDRESS:_____

☐ **I DO NOT WISH TO HAVE EITHER. PLEASE JUST CALL.**

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PATIENT RECORD OF DISCLOSURES

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 RY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

____HOME PH:_____

_____O.K. to leave message with detailed information

_____Leave Message with call back number only

____Work Ph:_____

_____O.K. to leave message with detailed information

_____Leave Message with call back number only

____Written Comunication

_____O.K. to mail to home address

_____O.K. to mail to work address

_____O.K. to fax to this number:_____

I authorize Coastal Dermacology PA to discuss ty PHI with the following individual

_____
Name of Authorized Individual

_____ _____
Patient Signature Date

_____
Printed Name

COASTAL DERMATOLOGY, PA

Receipt of Notice of Privacy Practices Written Acknowledgement Form:

I am a patient of COASTAL DERMATOLOGY & Medspa. I hereby acknowledge receipt of the Coastal Dermatology & Medspa's Notice of privacy Practice.

Name and Date of Birth: (please print)_____

Signature:_____

Date:_____

Or

Iam a patient or legal guardian of_____(patient name). I hereby acknowledge receipt of COASTAL DERMATOLOGY & Medspa's Notice of Privacy Practices with respect to the patient.

Name: (please print)_____

Relationship to the patient:_____Parent _____Legal Guardian

Signature:_____

Date:_____