

ORLANDO DERMATOLOGY CENTER

NEW PATIENT REGISTRATION FORM

A. PATIENT INFORMATION.

TODAY'S DATE ____/____/____

NAME _____ DOB _____

GENDER ____ HEIGHT ____ WEIGHT ____ MARITAL STATUS ____ CELL PHONE ____ - _____

ADDRESS: _____ Apartment # _____

CITY _____ STATE ____ ZIP ____ WORK PHONE ____ - _____

E-MAIL _____

REFERRING DOCTOR/PROVIDER _____ PHONE _____

B. PARENT OR RESPONSIBLE PARTY (ONLY IF DIFFERENT FROM THE PATIENT).

NAME _____ DOB _____

GENDER ____ MARITAL STATUS ____ CELL PHONE ____ - _____

ADDRESS: _____ Apartment # _____

CITY _____ STATE ____ ZIP ____

WORK PHONE ____ - _____ E-MAIL _____

C. HEALTH INSURANCE INFO.

PRIMARY INSURANCE NAME _____ MEMBER ID # _____ EFFECTIVE DATE _____

SECONDARY INSURANCE NAME _____ MEMBER ID # _____ EFFECTIVE DATE _____

D. PHARMACY NAME, ADDRESS, PHONE #

Health History Form

Name: _____

Date of Birth: _____ Today's Date: _____

Do you have or have you ever had diseases or conditions of (please check Yes or No)

Respiratory:			Other Systemic:			
Bronchitis	Yes	No	Hepatitis	Yes	No	
Emphysema	Yes	No	Diabetes	Yes	No	
Asthma	Yes	No	Thyroid Problems	Yes	No	
Chronic Cough	Yes	No	Kidney Disease	Yes	No	
Morning Cough	Yes	No	Dialysis	Yes	No	
Shortness of Breath	Yes	No	Bladder Problems	Yes	No	
Wheezing	Yes	No	Gastrointestinal			
Cardiovascular:			Stomach absorptive disorder	Yes	No	
High Blood Pressure	Yes	No	Nausea, vomiting, diarrhea			
Chest Pain	Yes	No	when taking antibiotics	Yes	No	
Heart Attack	Yes	No	Yeast infection when taking antibiotics	Yes	No	
Heart Murmur	Yes	No	Arthritis/joint Deformity	Yes	No	
Arrhythmia	Yes	No	Artificial Joint	Yes	No	
Phlebitis	Yes	No	Convulsions	Yes	No	
Hardening of the Arteries	Yes	No	Epilepsy, Seizures	Yes	No	
Artificial Valve	Yes	No	Fainting	Yes	No	
Pacemaker	Yes	No	Depression	Yes	No	
			HIV	Yes	No	

List any **other diseases or conditions:** _____

List **Surgeries** _____

List all **Medications:** (oral, injection, topical, including prescriptions, over-the-counter, and herbal.) _____

List all **Allergies:** _____

Skin: Have you ever had skin cancer? Yes No _____
 Family history of skin cancer? Yes No _____
 Do you have history of skin diseases? Yes No _____
 Do you have problems healing? Yes No _____
 Do you develop keloid/raised scars after surgery? Yes No _____
 Do you bleed easily? Yes No _____
 Do you get rashes from Medication Food Environment Ointments Other _____

Social History:
 Do you drink alcohol? Yes _____ / day No
 Do you smoke? Yes How much? _____ No
 Do you use IV drugs? Yes How much? _____ No

What is your occupation? _____

(Women) Are you pregnant? Yes No Due date: ___/___/___ Breastfeeding: Yes No

Have you ever seen a dermatologist before? Yes No Why? _____

Reason for your visit today? _____

Informed Patient Consent

_____ I give my permission for Dr. Blatnoy, Dr. Vaysberg and staff of Dermatology and ENT Center to treat me as deemed necessary in the exercise of their professional judgment.

_____ I understand that medical care requires my cooperation.

_____ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

_____ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical care to third party payers, including Medicare. Consistent with HIPAA regulations, any release will be limited to only those records required to obtain payment.

_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor or medical group any benefits for services rendered.

_____ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

_____ I understand I may be billed by an outside laboratory for work 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.

_____ I received and read Notice of Privacy Practices. Patient Name _____

Standing Consent to Discuss Health Information

In many cases, HIPAA allows providers to share protected health information (“PHI”) with family members and friends that patients choose to involve in their health care or payment for their health care, so long as the patient does not object after having the opportunity to do so. The disclosure of certain sensitive information also requires a patient’s prior written consent. Please list below the name(s) of the individual(s) you authorize Dermatology and Skin Cancer Surgery Center to discuss your health care treatment and billing information with. Your PHI will be disclosed to the individual(s) listed below unless/until you notify us otherwise in writing.

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
		- -
		- -
		- -

I hereby release Dermatology and Skin Cancer Surgery Center and its employees from liability for any claims by me in connection with my participation. By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via a written request submitted to Dermatology and Skin Cancer Surgery Center or by completion of a new form.

Patient Name (Print) _____ Date _____

422 South Alafaya Trl, # 26, Orlando, FL 32828
Tel. 407-538-3855. Fax 407-459-8732

7560 Red Bug Lake Rd, #1014, Oviedo, FL 32765
Tel. 407-706-1770. Fax 407-706-1777

731 Stirling Center Place, # 1931, Lake Mary, FL 32746
Tel. 407-436-7375. Fax 321-363-0018

4970 South US Hwy 17 92, Casselberry, FL 32707
Tel. 407-635-8012. Fax 407-706-1777