DERMATOLOGY OF MIAMI
SUNSET DRIVE / MIAMI LAKES

George D. Glinos, MD, FAAD
Yesenia Sebastia, APRN-BC
Alexandra Riguero, PA-C
Bethany Aguilar, MCMSc, PA-C

PATIENT INFORMATION

Name:_____ Social Security No:_____/_____/_____/

Date of Birth:_____ Gender: M____/ F____ Marital Status: S___ M___ W___ D___

Address:_____ Apt. No._____ City / State:_____ Zip:_____

Telephone Home:_____ Cell:_____ Work:_____

Patients Email Address:_____

Pharmacy Info:_____

Primary Physician:_____ Telephone:_____

Referred By:_____

Spouse Name:_____

Legal Guardian (If Applicable):_____ Phone Number:_____

Legal Guardian Date of Birth: _____

Emergency Contact:_____ Telephone:_____ Relationship:_____

PATIENT EMPLOYER INFORMATION

Employer Name:_____ Telephone No._____

Address:_____ City:_____State:_____ Zip:_____

Patient Occupation:_____

PRIMARY INSURANCE — INFORMATION MUST BE COMPLETED

INSURANCE COMPANY:_____

INSUREDS NAME:_____ Relationship:_____ Date of Birth:_____

INSUREDS PHONE NUMBER:_____

SECONDARY INSURANCE

INSURANCE COMPANY:_____

INSUREDS NAME:_____ Relationship:_____ Date of Birth:_____

NOTE: Most HMO Insurance Companies allow 5 visits a year without an authorization from your Primary Care Physician.

PLEASE ANSWER THE FOLLOWING QUESTION:

I have_____ or have not_____ seen another dermatologist this year. If you have, please list the doctor's name and the number of times seen_____ . If you have been seen by a dermatologist 5 or more times, you may need an authorization. Please discuss this with our Front Desk Staff.

Date:_____ Signature:_____
(PATIENT, PARENT OR GUARDIAN)

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INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process this claim.

I hereby authorize George D. Glinos, MD to apply for benefits on my behalf for covered services rendered by him or by this order.

I request that payment from my Insurance Company be made directly to George D. Glinos, MD (or to the party who accepts assignment).

I Certify that the information I have reported with regard to my Insurance coverage is correct. If this information is incorrect, the office may bill me for the full amount for any date of service applicable.

Any unpaid balances may be forwarded to a Collection Agency. At that time a $25.00 Processing Fee will be added to your invoice. This does not include the Collection Agency Fees.

I permit a copy of this authorization to be used in place of the original. This authorization can be revoked at any time by myself or my Insurance Company.

Date:_____ Signature:_____

(PATIENT, PARENT OR GUARDIAN)

GENERAL MEDICAL INFORMATION

Height:_____ Weight:_____

Reason for today's visit:_____

List all medications you are presently taking:_____

Allergies:_____

Other physician currently treating you:_____

List any surgeries or hospitalizations:_____

Females only: Are you pregnant, planning a pregnany or nursing a child?: Yes:_____ No:_____

Do you smoke? Yes:_____ No:_____ No. of Years:_____ How much?_____ Interested in stopping?_____

Do you regularly drink alcohol? Yes:_____ No:_____ How much ounces / beers per day?_____

Do you regularly drink coffee? Yes:_____ No:_____ How much cups per day?_____

Are you under a lot of pressure at work? Yes:_____ No:_____ Please describe:_____

FAMILY HISTORY

Psoriasis_____	Eczema_____	Asthma/Hay Fever_____
Skin Cancers:		
Melanoma_____	Basal Cell_____	Squamous Cell_____
Heart Disease_____	Stroke_____	Cancer_____
Diabetes_____	High Blood Pressure_____	Kidney Disease_____
Hepatitis_____	Depression_____	

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GENERAL RECORDS RELEASE AUTHORIZATION

Your Medical Records or Laboratory Results may be requested by your Primary Family or Specialist Physician to coordinate your care. I authorize George D. Glinos, MD and/or staff to send records to the requesting physician or lab.

Please list any family member or friend that may access your Health Information or speak with the Doctor or Staff in reference to you.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date:_____ Signature:_____

(PATIENT, PARENT OR GUARDIAN)

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EXHIBIT 1
Revised February 1, 2013
WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have (1) received a copy of the **Notice of**
Patient Name
the Privacy Practices or (2) has been offered a copy of the **Notice of the Privacy Practices** but declined to accept a copy.

Signature of Patient:_____ Date:_____

WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the_____ day of_____, 20__, the **Notice of Privacy Practices** was _____ offered and/or given to_____.
Patient Name

_____ The Patient accepted a copy of the **Notice of Privacy Practices** but refused to sign An acknowledgement that it was given to the patient.

_____ The Patient refused to accept a copy of the **Notice of Privacy Practices** and refused to sign an acknowledgement that it was offered to the patient.

Signature of Employee:_____ Date:_____
that offered to the Patient the
Notice of Privacy Practices

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DATE: _____

Effective September 1,2023 all cancellations made with less than one full business days' notice may result in a cancellation fee of **$50.00** If I fail to show for my scheduled General Medical appointment, I may be charged a no-show fee of **$50.00.**

I understand that **two** full business day cancellation notice is required for all **Cosmetic and Surgical** Appointments. All cancellations made with less than two full business days' notice may result in a cancellation fee of **$100.00**. If I fail to show my Cosmetic or Surgical appointment, I may be charged a no-show fee of **$100.00** and forfeit any applicable deposit.

I understand that all patients are given a 15-minute grace period from their scheduled appointment. The practice cannot guarantee that patients who arrive 15 minutes past their scheduled appointment time will be seen and may need to be rescheduled.

I have read and fully understand my responsibilities regarding the office cancellation and late policy listed above.

Thank you,

George D. Glinos M.D.

I Certify by my signature below that I have read and understand the appointment charge agreement.

Print name Signature Date