DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING?

Please indicate with an __X__.

Personal History

______ Reactions to local anesthetic:
(Allergy, fainting, rapid heart beat)
______ 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)

____
____
____
____
____
____
____
____
____

Do we have your permission to discuss your medical condition with a member of your family?
______ yes ______ no … If yes:
Whom? _________________________________
Relationship? ____________________________
Phone #: _________________________________

____
Patient Signature

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

MEDICARE 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 ________________________Employer ___________________Day Phone ________

Family Physician ______________________ Referring Physician ______________________

Secondary Insurance Information: Name of Ins. Co. ___________________________

Name of Policy Holder ________________________________ Birthdate ________________

Patient Relationship to policy holder ____Self ____Spouse ____Child ____Other:___________

☐ Yes ☐ No **Have you recently joined a Medicare HMO? If yes, __________________**

☐ Yes ☐ No **Do you or your spouse have insurance coverage through a current employer?**

☐ Yes ☐ No **Are you covered by a HMO/PPO which makes Medicare secondary?**

☐ Yes ☐ No **Are you receiving Medicaid?**

This office is required to have your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Regulations pertaining to Medicare assignment of benefits apply.
Please read and sign the following statement:

> *"I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment."*

_______________________________________ ______________________
Signature as it appears on Medicare card Date

If you have a **supplemental policy** and it is a secondary policy to which your Medicare carrier automatically crosses over, we are required to have a separate signature on file:

> *"I request authorized filing for secondary benefits to be made on my behalf for any services furnished me. I authorize any holder of medical information to release to the above secondary carrier any information needed to determine these benefits or the benefits payable for related services."*

_______________________________________ ______________________
Signature as it appears on secondary card Date

We are sorry to impose on you with another form.

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

Name ____ Date ____________________

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

Smoking Status:

Every day smoker

Current some day smoker

Former smoker

Never smoker

Alcohol Use (# of drinks):

________ drinks daily / weekly / monthly
(circle one)

Have you had the following vaccines?

Pneumonia Y N

Flu Y N

Preferred Language: ____________________

If 65 or older:

Do you have an advanced directive? Y N

Who is your surrogate? (optional)

Name:____________________________________

Preferred Pharmacy: (fill in below)

Pharmacy Name	Address City Zip	Phone

***Your visit summary will be available for you for viewing within four business days via your secure patient portal. Your account will be available via login information that will be emailed to you by INGAGE.

Email Address: ____

<u>Florida Dermatology Associates</u>
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: _________________________

Name: _________________________________ Phone Number: _________________________

Name: _________________________________ Phone Number: _________________________

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