

# 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)

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## **Allergy to medications:**

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## **Do you take any blood thinners?**

aspirin / coumadin / ecotrin / plavix  
vitamin e / ginko biloba / ticlid

## **Do you take any vitamins, supplements, herbal products?**

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Do we have your permission to discuss your  
medical condition with a member of your family?

yes  no ... If yes:

Whom? \_\_\_\_\_

Relationship? \_\_\_\_\_

Phone #: \_\_\_\_\_

**“I understand the removal of a skin  
growth may leave a permanent scar.”**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**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 \_\_\_\_\_ Employer \_\_\_\_\_ 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.

Your signature below indicates:

- You understand and accept the above policy regarding payment
- 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

# 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

### **Alcohol Use (# of drinks):**

\_\_\_\_\_ drinks daily / weekly / monthly

(circle one)

### **Race:**

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

Caucasian

Unknown

Decline to specify

### **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:** \_\_\_\_\_

### **Smoking Status:**

Every day smoker

Current some day smoker

Former smoker

Never smoker

### **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:** \_\_\_\_\_

# 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: \_\_\_\_\_

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