

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)**

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?

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 _____ 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

**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

Men: How many times in the last year have you had more than 5 drinks in a day? _____

Women: How many times in the last year have you had more than 4 drinks in a day? _____

For patients 65 and older: Have you had received a pneumonia vaccine?

Y N

Have you had received a flu vaccine?

Y N

Preferred Language: _____

Do you have a healthcare proxy?

Y N

Name: _____

Phone #: _____

Do you have a living will?

Y N

Preferred Pharmacy: (fill in below)

Pharmacy Name	Address	City	Zip	Phone

Email: _____

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: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

- 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