Florida Skin Cancer & Dermatology Specialists, PA

Patient Registration Information

Patient Information:

Patient Name: _____ _____ _____ _____
Salutation First MI Last

Birth Date: _____ Address: _____
Street/Apt#

☐ Male ☐ Female _____ _____ _____
City State Zip Code

Home Phone: _____ Daytime Phone: _____ Cell Phone: _____

SS#: _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown

Email: _____ Employer: _____

Primary Physician: _____ Referred By: _____

Ethnicity/Language:

Ethnic Group: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Asian ☐ Other: _____

Language: _____

Emergency Contact: _____ Phone: _____

Guarantor Information (Please complete if patient is a minor):

Guarantor Name: _____ _____ _____ _____
Salutation First MI Last

Relationship to patient: _____ Address: _____
Street/Apt#

SS#: _____ _____ _____ _____
City State Zip Code

Primary Insurance: _____

Secondary Insurance: _____

Financial Policy

Co-payments and/or deductibles are due at time of Service. We accept Visa, MasterCard, check or cash. Returned checks are subject to a $20.00 fee. Medical Record requests, $0.20 per page up to the first 25 pages. After this the amount will be $1.00 per page. Cancer Policy requests, $20.00 fee.

Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier in order to remain informed of your benefits.

Authorization to Release Information and Authorization for Treatment

I hereby authorize release of any medical information necessary to process my insurance claims. I also authorize Florida Skin Cancer & Dermatology Specialists, PA to provide medical care or such treatment as deemed necessary.

Patient Name (please print): _____ **Date:** _____

Parent or Guardian (please print): _____

Signature of Patient OR Guardian: _____

MR# _____

Florida Skin Cancer & Dermatology Specialists, P.A.

NOTICE OF PRIVACY PRACTICES
as required by the privacy regulations created as a result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of your health information, and to provide you with this notice of our legal duties and privacy policies maintained in our practice.

Uses and Disclosures

****Treatment***: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. We may also use your health information to dispense prescribed medicines and/or medical supplies to you.

****Payment***: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

****Law enforcement***: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

****Public health reporting***: Your health information may be disclosed to public health agencies as required by law.

****Business Associate Agreements:*** These are individuals or a business, other than Florida Skin Cancer & Dermatology Specialists, employees who perform "functions or activities" on behalf of the practice that involve, receive, maintain or possibly transmit personal health information. The agreements between Florida Skin Cancer & Dermatology Specialists and the Business Associate have a set forth signed agreement in place and are expected to use "reasonable diligence" in monitoring their work.

****Other uses and disclosures require your authorization:*** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Any Breach or Protected Health Information that has been compromised will be reported by Florida Skin Cancer & Dermatology Specialists, PA.

If you have any questions about this notice, please contact
Noelle Hagan
Business Manager
Florida Skin Cancer & Dermatology Specialists, P.A.
352-371-7546

I have read and understand the Notice of Privacy Practices for Florida Skin Cancer & Dermatology Spec, P.A. I realize that I can request a copy of this notice at any time.

Patient or Representative Signature **Date**

Witness

Florida Skin Cancer & Dermatology Specialists, PA
3700 NW 83rd Street
Gainesville, FL 32606
(352)371-7546

Release of Information

Because of the HIPAA guidelines, Florida Skin Cancer & Dermatology Specialists is unable to release medical information to anyone not listed on this form. This medical information includes biopsy results, lab results and all other medical information pertaining to one's medical treatment.

I authorize Florida Skin Cancer & Dermatology Specialists, to release my medical information to:

Primary Care Physician: _____
Other Physician(s): _____

_____

_____

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

May we leave a message regarding your health or an upcoming appointment on your answering machine? ◯ **Yes** ◯ **No**

_____ _____
Print Patient Name **Date**

_____
Patient Signature

MR# _____

Florida Skin Cancer & Dermatology Specialists, PA

Patient Information Form Name: _____

Pharmacy _____ Pharmacy Phone, Location, Intersection _____

Allergies to Medications: ☐ **None** 1) _____ Reaction: _____
2) _____ Reaction: _____

Current Medications (including eye drops and OTC): ☐ **None**

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Aspirin Daily ◯ Yes ◯ No Blood Thinners ◯ Yes ◯ No Motrin/Advil Daily ◯ Yes ◯ No

Birth Control Pills ◯ Yes ◯ No Are you Pregnant ◯ Yes ◯ No Plan on becoming pregnant ◯ Yes ◯ No Are you breastfeeding ◯ Yes ◯ No

Review of Systems

Current or past problems with:	Yes	No	(If yes, please explain)		Yes	No	(If yes, please explain)
Blood/Bleeding Disorder	◯	◯		Received Blood Transfusion	◯	◯	
Heart Disease	◯	◯		Psychological Disorders	◯	◯	
Kidney Disease	◯	◯		Ear/Nose/Throat Disease	◯	◯	
Liver Disease or Hepatitis	◯	◯		Cancer (Non-skin)	◯	◯	
Lung Disease	◯	◯		Immunologic Disease	◯	◯	
Thyroid Disease	◯	◯		Latex/Rubber/Nickel Allergy	◯	◯	
Arthritis	◯	◯		Skin Disease	◯	◯	
Diabetes	◯	◯		Skin Cancer	◯	◯	
High Blood Pressure	◯	◯		Melanoma	◯	◯	
Infectious Disease	◯	◯		Eye Disease	◯	◯	

Do you:

Have a Pacemaker or defibrillator	◯ Yes	◯ No	Have an artificial joint or heart valve	◯ Yes	◯ No
Take antibiotics prior to surgical procedures	◯ Yes	◯ No	Form Keloids (thickened scars)	◯ Yes	◯ No
Have a history of Malignant Melanoma	◯ Yes	◯ No	Have a primary care physician	◯ Yes	◯ No

Have you:

Ever been screened for unhealthy alcohol use	◯ Yes	◯ No	Been through tobacco screening in the last two years	◯ Yes	◯ No
Had a flu vaccination in the last year	◯ Yes	◯ No	Received a pneumonia vaccination	◯ Yes	◯ No
Received the shingles vaccination	◯ Yes	◯ No	All medications are up to date?	◯ Yes	◯ No

List Surgeries:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Family History:

Check the following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative
Acne	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Hay Fever	☐	☐	☐
Hives	☐	☐	☐
Lupus	☐	☐	☐
Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Skin Cancer	☐	☐	☐

Social History

Do you live alone	◯ Yes	◯ No			
Do you smoke	◯ Yes	◯ No	Frequency: _____	Have you used a Tanning Bed	◯ Yes ◯ No
Do you drink alcohol	◯ Yes	◯ No	Frequency: _____	Do you use Recreational Drugs	◯ Yes ◯ No

Occupation: _____ Hobbies/Leisure Activity: _____

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Patient Information Form Name:

Please check any of the symptoms you are currently having:

Hematology:

- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Frequent infections
- ☐ Increased Fatigue
- ☐ Swollen glands/lymph nodes

Cardiovascular:

- ☐ Chest pain
- ☐ Heart racing
- ☐ Swelling of ankles
- ☐ Leg cramping

Urology:

- ☐ Urinary urgency
- ☐ Urinary Frequency
- ☐ Difficulty initiating urine stream
- ☐ Pain in urination
- ☐ Blood in urine
- ☐ Flank pain
- ☐ Discharge

Gastroenterology:

- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Blood in stool
- ☐ Dark tarry stool
- ☐ Yellow color of skin or eyes

Allergy/Immunology:

- ☐ Difficulty breathing
- ☐ Swelling of throat
- ☐ Enlarged or tender lymph nodes
- ☐ Itchy eyes

Pulmonology:

- ☐ Cough
- ☐ Dyspnea
- ☐ Hemoptysis
- ☐ Wheezing
- ☐ Pleuritic chest pain

Endocrine- Thyroid:

- ☐ Intolerance to heat
- ☐ Intolerance to cold

Musculoskeletal:

- ☐ Muscle weakness
- ☐ Joint swelling
- ☐ Joint pain

Endocrine- Diabetes:

- ☐ Increased thirst
- ☐ Increased frequency of urination
- ☐ Slow wound healing

Neurology:

- ☐ Disorientation
- ☐ Dizziness
- ☐ Abnormal gait
- ☐ Headaches
- ☐ Muscles weakness
- ☐ Sensory problems
- ☐ Paralysis
- ☐ Seizures
- ☐ Stroke
- ☐ Numbness
- ☐ Speech problems