Associates In Dermatology

Caring for Southwest Florida for over 40 years

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Associates in Dermatology's Notice of Privacy Practices.

Further, 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. Regulations pertaining to medical assignment of benefits apply.

May we mail to your home or other designated location any items that assist the practice in carrying treatment/healthcare operations, such as appointment reminders, insurance items, and lab results?

YES NO

May we leave a message with a **member of your household** regarding appointments, lab results, and insurance?

YES NO

If yes, whom: ______________________________ Relationship_______________

If yes, whom: ______________________________ Relationship_______________

May we leave a message on an **answering machine/voice message** regarding appointments, lab results, and insurance?

YES NO

If employed, may we contact you at your work place?

YES NO

I understand the contents of this Notice.

____

Patient or Legal Guardian Signature (If under 18 parent/legal guardian/relation to patient) Date

Diplomates, American Board of Dermatology

8381 Riverwalk Park Blvd. #101 & #202 Fort Myers, FL 33919 (239) 936-5425 – Fax (239) 936-3591
14 North Del Prado Blvd. #301 Cape Coral, FL 33909 (239) 772-1909 – Fax (239) 772-9742
3665 Tamiami Trail #104 Punta Gorda, FL 33950 (239) 936-5425 Fax (239) 936-3591

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MEDICAL HISTORY

Name ______________________________ **Chart #** ______________ **Date** __________

Reason for today's visit: ____

List Current Medications: ____

____

Pharmacy: ______________________________ Telephone: ____________________

Do you have a Heart Pacemaker or Defibrillator? □ **Yes** □ **No**

Blood Thinners

□ Aspirin	□ Advil / Ibuprofen	□ Aggrenox	□ Brilenta
□ Eliquis	□ Pradaxa	□ Plavix	□ Coumadin/Warfarin
□ Xarelto	□ Fish oil	□ Ginko	□ Vitamin E

Other: ____

Medicine Allergies

□ Lidocaine	□ Novocaine	□ Epinephrine	□ Keflex
□ Penicillin	□ Tetracycline	□ Sulfa	□ Erythromycin
□ Aspirin	□ Neosporin	□ Polysporin	

Others: ____

Current and Past Medical Conditions

		□ Arthritis	□ Asthma	□ Alzheimer/Dementia
□ Bronchitis	□ Convulsions	□ Diabetes	□ Easy Bleeding	□ Emphysema
□ Eczema	□ Epilepsy	□ Fainting	□ Heart Attack	□ Heart Valve Replace
□ Hepatitis	□ High Blood Pressure	□ HIV (AIDS)	□ Stroke	□ Irregular Heart Beat
□ IV Drug Use	□ Joint Replacements	□ Liver Disease	□ MVP (Mitral Valve Prolapse)	
□ Phlebitis	□ Stomach Ulcers	□ Thyroid Disease	□ Tuberculosis	

□ Skin Cancer, what type? ______________________ □ Cancer, what type? __________________

Others: ____

Are you pregnant? □ **Yes** □ **No** If yes, __________Months

Has a blood relative had Skin Cancer? If yes, who and what kind? ___________________________

______________________________ If not patient, please indicate relationship: ______________

Signature of Patient or Legal Representative

Physician Signature: ______________________________ **Date:** ______________

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Patient Registration Chart #____________________

Name: ____ DOB: ____________________
Last Name MI First Name

Address: ______________________________________City: _______________State ______Zip___________

Home# _______________________Other #_______________________SS#____________________________

Marital Status: M W D S Sex: F M Student: FT PT Employment Status: F P R N/A

Spouse's Name ___________________ Patient's employer name: _________________________________

Primary / Referring Physician: ____

Insurance Information (from your insurance card)

Primary Insurance Name: ____

Claims Address: ___________________________________ City _______________ State _____ Zip_________

Insurance ID#____________________________________Group#_____________________________________

Subscriber Name ____________________ SS# ____________________ Subscriber DOB _________________

Subscriber Employer____

Patient Relationship to Subscriber: Spouse ___________ Child _____________ Other_________________

Secondary Insurance Name: ____

Claims Address: ___________________________________ City _______________ State _____ Zip_________

Insurance ID# _______________________________________ Group#_________________________________

Subscriber Name _______________________ SS# _________________ Subscriber DOB _________________

Subscriber Employer____

Patient Relationship to Subscriber: Spouse ___________ Child _____________ Other________________

Medicare Patients
I authorize Associates in Dermatology to release to the Social Security Administration and Health Care Finance, or its intermediaries, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Associate in Dermatology. Release of Information
I authorize the release of medical information to my primary care or referring physician, and as necessary to insurance companies to process insurance claims, insurance applications and prescriptions.
I understand that I am ultimately responsible for any/all services rendered to me at the time of service.

____ Date ________________________
Patient or Legal Guardian Signature (If under 18 parent/legal guardian/relation to patient)

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