



Robert S. DiBacco, MD

NEW PATIENT INTAKE

Welcome to our practice!



Robert S. DiBacco, MD

NEW PATIENT INFORMATION

Date _____

Patient Name: Last _____ First _____ Middle _____ Date of Birth _____

Male Female Married Single Widowed Divorced

Primary Address _____ City _____ State _____ Zip _____

Seasonal Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Alternate Number _____

Primary Care Physician _____ Phone _____

Referred by _____ Physician _____ Yes No

Email Address _____

Preferred Method of Contact for appointment reminders: Cell Home Work Text Email

If under 18 years of age, name of parent or guardian _____

Patient/parent/guardian's occupation _____

Employer Name _____ Address _____ Employer Phone _____

Emergency Contact person not residing with you _____ Phone _____

Relationship to you: Friend Relative Other _____

LIFETIME AUTHORIZATION

For the Release of Medical Records

I authorize the release of any medical information required by my insurance carrier(s) needed for this or any related claim. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Health Care Financing Administration or its intermediaries or carriers any information needed for this insurance claim or any related medical claim

For the payment of benefits to the Physician/Provider

I, the undersigned, understand that Palm Beach Dermatology has agreed to accept Medicare and/or health insurance for payment of my bills by my signature below. I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance due after Medicare/Health insurance payments and will be paid by me to Palm Beach Dermatology. I understand that I will be billed for the remaining unpaid balance and I understand that I am financially responsible for any charges not covered by this authorization.

Patient Signature _____ Date _____

METHOD OF PAYMENT

Payment is required at the time services are rendered. Palm Beach Dermatology is a participating provider with Medicare, Blue Cross Blue Shield of Florida, and many other PPO Insurance plans. Please check with our front desk staff to see if we participate with your health care insurance plan. Preferred Provider Plans (PPO) medical claims will be filed automatically by our office. Please present your insurance card(s) to our front desk staff for photocopy/scanning and benefit verification.

Will you be paying by: Cash Check Credit Card *Valid State ID or Driver's License is required if paying with Credit Card or Check*

The information requested on this form must be completed in its entirety and will remain confidential. Your selection of Palm Beach Dermatology for your care is greatly appreciated. If you have any questions or require assistance please do not hesitate to ask. We are happy to be of service to you.

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Patient Name _____ Date _____

Primary (Default) Pharmacy Name _____ Phone _____

Past Medical History

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> GERD | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Underactive Thyroid | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other _____ |

Past Surgical History

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Gallbladder Removal |
| <input type="checkbox"/> Pancreas Removed | <input type="checkbox"/> Spleen Removed | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Ovaries Removed |
| <input type="checkbox"/> Coronary Artery Bypass Surgery | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Testicle Removed | <input type="checkbox"/> Colon Removed |
| Breast: <input type="checkbox"/> Biopsy | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| Heart: <input type="checkbox"/> Valve Replacement | <input type="checkbox"/> Biological | <input type="checkbox"/> Mechanical | <input type="checkbox"/> Transplant <input type="checkbox"/> Stent |
| Liver: <input type="checkbox"/> Liver Removal | <input type="checkbox"/> Transplant | <input type="checkbox"/> Shunt | |
| Knee Replacement: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | | Hip Replacement: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | |
| Kidney: <input type="checkbox"/> Biopsy | <input type="checkbox"/> Cancer <input type="checkbox"/> Tumor | Rectum: <input type="checkbox"/> APR | <input type="checkbox"/> Low Anterior Resection |
| Skin: <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Skin Biopsy | <input type="checkbox"/> Squamous Cell Carcinoma |
| Other: _____ | | | |

Skin Disease History

- | | | | | |
|--------------------------------------|--|--|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Actinic Keratosis (precancer) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Blistering Sunburns |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Eczema | <input type="checkbox"/> Flaking/Itchy Scalp | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Precancerous Moles | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Squamous Cell Carcinoma | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Other _____ | | | | |

Do you wear sunscreen Yes No SPF _____ Do you use tanning salon? Yes No

Do you have a family history of Melanoma? Yes No Which relative? _____

Medications _____

Allergies _____

Smoking status Never smoked Former smoker Sometimes Everyday Number of packs per day _____

Alcohol use None Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men _____

How many times in the past year have you had 4 or more drinks in a day for women _____

Illicit Drug Use

Drug use

IV drug use

For patients 65 and older

Have you received a pneumonia vaccination

Yes

No

Have you received a flu shot (January through March or October through December)

Yes

No

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Yes

No

Designated Health Care Proxy name _____ Phone _____

Do you have a Living Will Yes

No

Family History

Please check if any blood relative has any condition(s) listed below

Allergies/Hay fever Family Member _____ Childhood eczema Family Member _____

Asthma Family Member _____ Psoriasis Family Member _____

Diabetes Family Member _____ Skin cancer Family Member _____

Other cancer Family Member _____ Heart disease Family Member _____

High blood pressure Family Member _____ Autoimmune disease Family Member _____

Other _____ Family Member _____

Review of systems

Problems with bleeding

Cough

Problems with healing

Shortness of breath

Problems with scarring (hypertrophic/keloid)

Wheezing

Rash

Anxiety

Immunosuppression

Depression

Hay fever

Changing moles

Chest pain

Allergy to adhesive

Fever or chills

Allergy to lidocaine

Night sweats

Allergy to topical antibiotic ointments

Unintentional weight loss

Artificial heart valve

Thyroid problems

Artificial joints within past two years

Sore throat

Blood thinners

Blurry vision

Defibrillator

Abdominal pain

MRSA

Bloody stool

Pacemaker

Bloody urine

Premedication prior to procedure

Joint aches

Rapid heartbeat with epinephrine

Muscle weakness

Pregnancy or planning pregnancy

Neck stiffness

West Africa: travel/contact

Headaches

HIV AIDS

Seizures

None



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CONSENT AND ACKNOWLEDGMENT

I authorize Palm Beach Dermatology, Inc. personnel to perform dermatology (skin care services. This authorization includes, but is not limited to, performing medically necessary surgical procedures such as a skin biopsy, removal of pre-cancerous and cancerous skin lesion. I consent to the disposition by Palm Beach Dermatology, Inc. of any tissue parts which may be removed. I understand that there are always certain risks and consequences that are associated with the aforesaid procedures. These among others, are scarring, pigmentary changes to the skin, recurrence of skin cancer or other lesions/problems and possible damage to blood vessels, or parts next to them, such as nerves, infection or allergic reactions or other complications. I acknowledge that no guarantee or assurance has been made to me as to any of their results or risks and I assume such risk. I understand that the practice of medicine is not an exact science. I will ask if I want to have further explanation, discussion, or description of the risks involved in these procedures.

I consent to the disposition by Palm Beach Dermatology, Inc., of any tissue parts, which may be removed from named patient. I understand that this tissue will be sent for pathologic evaluation to a board certified dermatopathologist and that named patient will be financial responsible for all the charges related to this evaluation regardless of the reimbursement from insurance carrier. I also understand that I will not hold Palm Beach Dermatology, Inc. professionally or personally responsible for the pathologic interpretation of said tissue and that this tissue may be sent for additional tests or evaluation by me or my insurance company's expense.

FOR PATIENT'S UNDERGOING SKIN CANCER TREATMENT OR EVALUATION

I understand that if I have skin cancer, it is my responsibility to seek follow up care by Palm Beach Dermatology, Inc. personnel or other dermatology professional at a minimum of six months. Failure to seek follow up care is my responsibility and I do not hold Palm Beach Dermatology, Inc. personnel professionally or personally responsible for skin cancer follow up. It is also the patient's responsibility to contact the office immediately if there is a change in appearance or sensation of a previously treated or evaluated skin growth or new growth (such as but not limited to color, size, shape, pain, bleeding, etc.)

Patient Name (Print) _____ Date of Birth _____

Signature/Patient, Parent or Legal Guardian _____ Date _____



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NOTICE OF PATIENT PRIVACY PRACTICES CONSENT

I, _____ have been given the opportunity to read a copy of
(Print Patient Name)

Palm Beach Dermatology’s NOTICE OF PATIENT PRIVACY PRACTICES.

Patient Signature _____ Date _____

Parent or Legal Guardian Signature _____ Date _____

May we leave appointment information on your answering machine? Yes No

Please be advised we are unable to leave any lab or pathology results on an answering machine.

Do you authorize our office to discuss your medical information with family members or other individuals?

Yes No

If yes, please provide names and phone numbers below:

Name _____ Relationship _____

Phone _____ Alternate Phone _____

Name _____ Relationship _____

Phone _____ Alternate Phone _____