PALM BEACH DERMATOLOGY

Michelle E. Muhart, MD

NEW PATIENT INTAKE

Welcome to our practice!

PALM BEACH DERMATOLOGY

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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_____

Email Address_____

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

Referred by_____Physician_____ ☐ Yes ☐ No

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: ☐ Spouse ☐ 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 UPDATE

Patient Name _____Date of Birth_____Date_____

Reason for your visit today_____

Medications you are allergic to_____

Describe reaction you had_____

Medications you are currently taking, including over the counter medications, multivitamins, birth control, blood thinners, and hormone therapy_____

_____

Check any of the following conditions you have:

☐ High Blood Pressure ☐ Heart Attack ☐ Chest Pain ☐ Valve Replacement ☐ Pacemaker ☐ Irregular or Fast Heart Beat
☐ Other Heart Problems
_____

☐ Breathing Problems ☐ Asthma ☐ List any other lung problems_____

☐ Kidney Disease ☐ Diabetes ☐ Hepatitis ☐ Blood Transfusions ☐ HIV/AIDS ☐ Artificial Joints
☐ Seizures ☐ Arthritis ☐ Radiation Treatment

List any other surgeries, hospitalizations, or medical problems you have had_____
_____

Do you presently use Sunscreen? ☐ Yes ☐ No If yes, what SPF Number?_____

Have you had any of the following?

☐ Skin Cancer ☐ Melanoma ☐ Precancers ☐ Sun Sensitivity ☐ Blistering Sunburn ☐Allergies ☐ Eczema
☐ Psoriasis ☐ Acne ☐ Poison Ivy ☐ Itchy Flaking Scalp ☐ Dry Skin ☐ Hay fever

Have you ever had difficulty stopping bleeding? ☐ Yes ☐ No
Do you require antibiotics PRIOR to any surgical or dental procedure? ☐ Yes ☐ No
Women: Are you pregnant? ☐ Yes ☐ No Or currently planning to become pregnant? ☐ Yes ☐ No
Has anyone in your family had any of the following?
☐ Eczema ☐ Allergies ☐ Hay fever ☐ Asthma ☐ Acne ☐ Skin Cancer ☐ Melanoma ☐ Sun Sensitivity ☐ Psoriasis
What is your occupation?_____
Have you had any occupational sun exposure or radiation exposure? ☐ Yes ☐ No
Have you had any occupational arsenic or petrol products exposure? ☐ Yes ☐ No
Where were you born?_____Number of years in Florida_____
Do you smoke? ☐ Yes ☐ No If yes, how much?_____
Do you drink beer, wine or liquor? ☐ Yes ☐ No If yes, how much?_____

Check any of the following that apply to you now or have in the past?

☐ Chicken Pox ☐ Shingles ☐ Tuberculosis ☐ HIV/AIDS ☐ Urinary Infection ☐ Asthma ☐ Emphysema
☐ Bronchitis ☐ Pleurisy ☐ Shortness of Breath ☐ Ulcer ☐ Colitis ☐ Gallstones ☐ Bloody Stool
☐ Persistent Vomiting ☐ Bloody Urine ☐ Stroke ☐ Difficulty Urinating ☐ Prostate Problems
☐ Hearing Loss ☐ Paralysis ☐ Loss of Strength ☐ Glaucoma ☐ High Cholesterol ☐ High Triglyceride

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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

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_____

Patient/Parent or Legal Guardian Signature_____Date_____

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ADVANCE CARE PLAN

(Patients Age 65 and Over)

Advance directives are designed to respect your autonomy and determine your wished about future life sustaining medical treatment if you are unable to indicate your wishes. Key interventions and treatment decisions are: resuscitation procedures such as Cardiopulmonary Resuscitation (CPR), and mechanical respiration (breathing tube)

Please check which statement best reflects your wishes on advanced care recommendations:

☐ I want full cardiopulmonary resuscitation efforts to be made (Full Code)

☐ I do not wish to have a breathing tube, even if it is necessary to save my life

(Do Not Intubate)

☐ If my heart were to stop, I do not wish to have chest compressions or any automated external defibrillator to restart my heart, even if it's necessary to save my life.

(Do Not Resuscitate)

☐ I have a Living Will

☐ I have health care proxy Name_____Phone _____

Patient Signature_____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_____