PALM BEACH DERMATOLOGY, INC. - REGISTRATION INFORMATION

NAME: ______________________________ HOME PHONE: __________
LAST FIRST MI

AGE: ___ DATE OF BIRTH__________ SEX: (M) OR (F) SOCIAL SEC. #:__________
mo/day/year

PERMANENT (LOCAL) ADDRESS:

____

CITY: ______________________ STATE: ____ ZIP: ________

CELL #:______________ EMAIL: ______________________

OUT OF STATE ADDRESS: ______________________________

CITY: ______________________ STATE: ____ ZIP: ________

OCCUPATION:______________ BUSINESS PHONE #: __________

EMPLOYER ADDRESS: ______________________________

EMERGENCY CONTACT PHONE & ADDRESS: ______________________

SPOUSE / PARENT:______________ ADDRESS: ______________

REFERRED BY: ______________________________

FAMILY PHYSICIAN: ______________________ TEL:__________

MEDICARE NUMBER: ______________________________

NAME OF SUPPLEMENTAL CARRIER: ____________ POLICY #:__________

ADDRESS: ______________________ PHONE: __________

INSURANCE CARRIER: ______________________ PHONE:__________

ADDRESS: ______________________________

POLICY #: ______________ GROUP #:______________

PERSON RESPONSIBLE FOR PAYMENT OTHER THAN SELF: ______________

PAYMENT IS TO BE MADE AT THE TIME SERVICES ARE RENDERED.
ANY OTHER ARRANGEMENTS MUST BE DISCUSSED WITH THE OFFICE MANAGER ***PRIOR*** TO YOUR CONSULTATION WITH THE DOCTOR.

470 COLUMBIA DRIVE, SUITE 102A • WEST PALM BEACH, FL 33409
PH: (561) 640-4400 • Fax: (561) 640-8098

MEDICAL HISTORY - PLEASE ANSWER ALL QUESTIONS

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Bleeding Disorders___	High Blood Pressure___	AIDS/HIV___
Diabetes___	Heart Attack/Stroke___	Asthma___
Glaucoma___	Heart Pacemaker___	Joint or Valve Replacement___
Hepatitis___	Defibrilator___	Malignant Melanoma___
Ulcers___	Venereal Diseases___	Penicillin Allergy___

Do you have a family history of skin cancer? Yes___ No___

If YES please indicate type of cancer; ______________________

List ALL other known allergies: ______________________

Recent operations (Last 3 Years)______________________

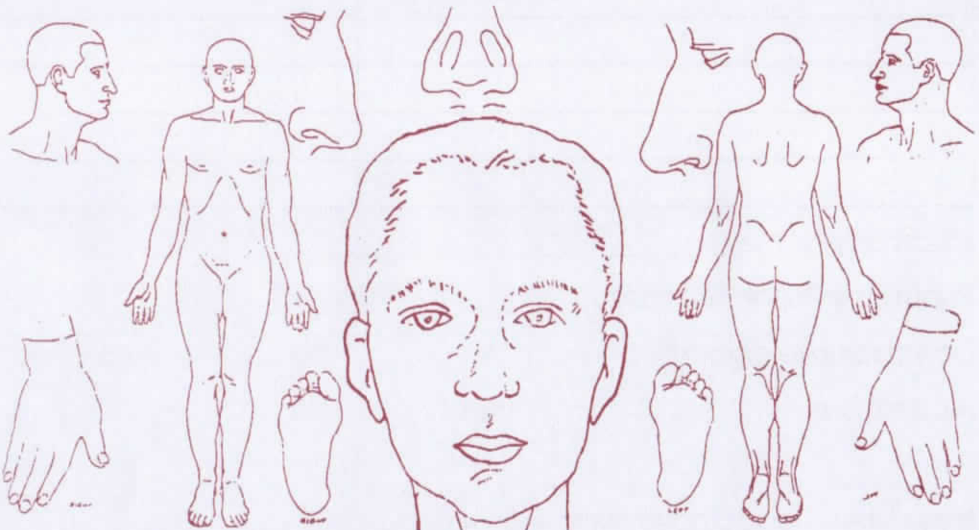
FEMALE PATIENTS: Are you pregnant? Yes / No - Planning to get pregnant? Yes / No
Are you breast feeding? Yes / No - Have you taken birth control pills? Yes / No

Briefly describe your current skin problem:______________________

____

How long have you had your present skin problem? ______________

Indicate on the diagram the affected part(s) of your body:



PLEASE DISCUSS WITH THE DOCTOR ANY OTHER HEALTH PROBLEMS OF WHICH YOU ARE AWARE
This information is accurate to the best of my knowledge. I understand that it is the patient's responsibility to notify the office and the doctor in the future if there is any change in my medical health or medications.

______________________________ ______________
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN DATE

Please list all your current medications, including over the counters, vitamins and or herbal supplements you take. If you have a list, please give us a copy

NAME	DOSAGE	FREQUENCY	ROUTE by mouth unless indicated otherwise

Pharmacy Name_______________

Pharmacy Phone Number _______________

Do you smoke cigarettes? Yes No Pack p/day_______________

Alcohol Use Yes No

If yes, Men: Do you have more than 4 drinks p/day_______________

If yes, Women: Do you have more than 3 drinks p/day_______________

Signature of Patient

Reviewed

Date

Palm Beach Dermatology, Inc.
Diplomates of the American Board of Dermatology
Fellows of the American Academy of Dermatology

CONSENTS AND ACKNOWLEDGEMENTS

1. 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 lesions. 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 lesion/problem, 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 the 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.

2. I consent to the disposition by Palm Beach Dermatology Inc., 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 financially 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 at my or my insurance companies' expense.

3. FOR PATIENTS 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 professionals at a minimum of every 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.).*

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN ____________________ DATE ____________

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

1. **PRIVACY PRACTICES:**

I have been given and have had the opportunity to read a copy of Palm Beach Dermatology, Inc.'s Notice of Patient Privacy Practices. The Notice of Privacy Practices describes the types and uses of disclosures of my protected health information which might occur in order to expedite medical treatment, payment of medical claims, or facilitate health care operations.

If you would like this office to be able to discuss your medical care with another person or family member, please authorize below.

NAME OF PERSON WE CAN DISCUSS YOUR CARE WITH ____________ RELATIONSHIP ____________

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN ____________ DATE ____________

2. MEDICARE PATIENTS:

I request payment of authorized Medicare benefits to be made either to me or on my behalf to Palm Beach Dermatology, Inc. for any services furnished me by that physician/facility. I understand that I am fully responsible for any yearly deductible, co-insurance or charges for non-covered service. I authorize any holder of hospital or medical information about me to release to CMS and its agents any information needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

SIGNATURE ____________ DATE ____________

3. **MANAGED CARE (HMO/ PPO) PATIENTS:**

I understand that I am responsible for all deductibles, co-payments, and charges for non-covered services at the time of my visit. I further understand that should payment from my insurer be denied due to "pre-existing illness exclusion", non- covered service or termination of coverage, that I will be responsible for payment of such services within 10 days of such notification. If such payment is not received timely then I will be responsible for the original full fee and any associated collection costs. It is also my responsibility to notify the office prior to my visit if there is any change in my insurance coverage.

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN ____________ DATE ____________

4. **CIGNA AND HUMANA HMO PATIENTS:**

I understand that my insurance company may limit me to no more than 5 visits to a dermatologist without pre-authorization in one calendar year and that it is the patent's responsibility to get a referral from the primary care provider if more than 5 visits are necessary. I further understand that if my insurance company denies payment for this reason that I will be financially responsible for those charges.

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN ____________ DATE ____________