Palm Beach Dermatology

Dr. Judith V. Redd

Today's Date: _____

PATIENT INFORMATION:

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

Address: _____ Apt. _____ City: _____ State: ____ Zip: _____

E-Mail Address: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Social Security Number: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced

Spouse / Partner Name: _____ Cell Phone: (____) _____

Employer: (company name if self-employed) _____ Occupation: _____

Pharmacy Name: _____ Pharmacy Phone Number (____) _____

Primary Physician: _____ Office Phone: (____) _____

Emergency Contact: _____ Relationship: _____ Cell Phone: (____) _____

INSURANCE INFORMATION:

PRIMARY: Insurance Policy _____ Member ID #: _____

Group #: _____ Insurance Customer Service Phone # (____) _____

Policy Holder's Information (*Only if different than patient*) First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Sex: ☐ Male ☐ Female Cell Phone: (____) _____

SECONDARY: Insurance Policy _____ Member ID #: _____

Group #: _____ Insurance Customer Service Phone # (____) _____

Policy Holder's Information (*Only if different than patient*) First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Sex: ☐ Male ☐ Female Cell Phone: (____) _____

COSMETIC QUESTIONNAIRE:

Do friends ever ask if you are tired or sad when you are not? ……☐ Yes ☐ No

How do you feel you look compared to your age? (Circle one) Younger than your age Your age Older than your age

On a scale of 1 to 10, how much does your answer to the previous question bother you? (Circle one) 1 2 3 4 5 6 7 8 9 10

1 = Not bothered at all 10 = Extremely bothered

HOW DID YOU HEAR ABOUT US?

☐ My Doctor ☐ Family Member ☐ Friend ☐ Advertisement ☐ Internet ☐ Insurance Directory ☐ Other _____

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RECORDS RELEASE & ASSIGNMENT OF BENEFITS:

I hereby authorize Dr. Judith V. Redd/DBA, Palm Beach Dermatology to release pertinent information regarding my care to other physicians involved in my case and / or insurance companies holding policies on me. I authorize my insurance company to directly remit payment to Palm Beach Dermatology for medical or surgical services provided and billed.

X _____ X _____ X _____

Print Patient Name *Signature* *Date*

FINANCIAL POLICY:

- Payment is due at the time of service, including co-payment and deductibles. All charges will become the patient's financial responsibility if your insurance carrier has not paid within 60 days.
- I understand that if blood work or biopsies are done, I may receive a separate invoice from the laboratory or the pathology doctor who reviews and interprets my biopsy specimens at a later date.
- I will be responsible for paying all such invoices directly to that laboratory or physician.
- We require at least 24-hour notice for appointment cancellations. While there is no charge for the first late cancellation or no-show, a card on file is required, and a $50 fee will be charged for any future missed appointments without proper notice.

I have read and fully understand the financial policy.

***** THIS SHOULD BE SIGNED BY THE PERSON RESPONSIBLE FOR PAYMENT*****

X _____ X _____ X _____

Print Patient Name *Signature* *Date*

AUTHORIZAION TO DISCUSS/RELEASE MEDICAL INFORMATION & BIOPSY RESULTS

☐ YES, I AUTHORIZE ☐ NO, I DO NOT AUTHORIZE, Palm Beach Dermatology employees may release my medical information by telephone communication to myself, or the identified people list on my HIPAA form

☐ YES, I AUTHORIZE ☐ NO, I DO NOT AUTHORIZE, Palm Beach Dermatology to leave medical information on my voicemail on this designated phone number (_____) _____

☐ YES, I AUTHORIZE ☐ NO, I DO NOT AUTHORIZE, Palm Beach Dermatology to send medical information to my email at this designated email address _____

***** FOR PATIENTS THAT ARE 65 AND OLDER *****

Do you have an Advanced Directive (Living Will)? ..... ☐ Yes ☐ No

Do you have a Health Care Proxy? ..... ☐ Yes ☐ No

If Yes, Health Care Proxy Name: _____

Relationship: _____ Cell Phone: (____) _____

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PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ AIDS
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia
- ☐ COPD
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ End-Stage Renal Disease
- ☐ Elevated Blood Pressure
- ☐ Epilepsy
- ☐ Gastroesophageal Reflux Disease
- ☐ History of Hypertension
- ☐ Hearing Loss
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Disease of Liver
- ☐ Leukemia
- ☐ Malignant Tumor of Breast
- ☐ Malignant Tumor of Colon
- ☐ Malignant Tumor of Lung
- ☐ Malignant Tumor of Prostate
- ☐ Radiation Therapy Treatment Management
- ☐ Transplantation of Bone Marrow

☐ Other _____

☐ None

PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ Abdominoperineal Resection
- ☐ Biopsy of Breast
- ☐ Biopsy of Prostate
- ☐ Coronary Artery Bypass Graft
- ☐ Entire Transplanted Kidney
- ☐ History of Appendectomy
- ☐ History of Bilateral Mastectomy
- ☐ History of Cholecystectomy
- ☐ History of Colectomy
- ☐ History of Colostomy
- ☐ History of Liver Excision
- ☐ History of Tissue Graft Heart Valve Replacement
- ☐ History of Total Cystectomy
- ☐ History of Tubal Ligation
- ☐ History of Transurethral Prostatectomy
- ☐ Hysterectomy
- ☐ Kidney Biopsy
- ☐ Lower Anterior Resection of Rectum
- ☐ Lumpectomy of Breast ☐ Right ☐ Left
- ☐ Mastectomy of Breast ☐ Right ☐ Left
- ☐ Mechanical Heart Valve Replacement
- ☐ Oophorectomy (Removal of Ovaries)
- ☐ Pancreatectomy
- ☐ Prostatectomy
- ☐ Replacement of Hip Joint ☐ Right ☐ Left
- ☐ Replacement of Knee Joint ☐ Right ☐ Left
- ☐ Splenectomy
- ☐ Total Nephrectomy
- ☐ Total Orchidectomy
- ☐ Transplant of Heart
- ☐ Transplant of Liver

☐ Other _____

☐ None

SKIN DISEASE HISTORY: (PLEASE CHECK ALL THE APPLY)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asteatosis Cutis
- ☐ Basal Cell Carcinoma
  Location _____ Year _____
- ☐ Dysplastic Nevus of Skin
- ☐ Eczema
- ☐ History of Hay Fever
- ☐ Malignant Melanoma
  Location _____ Year _____
- ☐ Pruritus of Scalp
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
  Location _____ Year _____
- ☐ Sunburn of Second Degree

☐ Other _____

☐ None

SKIN PROTECTION / FAMILY HISTORY: (PLEASE CHECK ALL THE APPLY)

☐ Do you wear sunscreen? ☐ Yes ☐ No If Yes, what SPF? _____

☐ Do you tan in a tanning salon? ☐ Yes ☐ No

☐ Do you have a family history of Melanoma? ☐ Yes ☐ No

If Yes, which relative (s)? _____

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SKIN PROTECTION / FAMILY HISTORY: (PLEASE CHECK ALL THE APPLY)

Do you have a pacemaker?	☐ Yes	☐ No
Do you have a defibrillator?	☐ Yes	☐ No
Do you require antibiotics prior to surgical procedure?	☐ Yes	☐ No
Do you have an allergy to adhesive?	☐ Yes	☐ No
Do you have an allergy to topical antibiotics ointments?	☐ Yes	☐ No
Are you taking any blood thinners, aspirin or fish oil?	☐ Yes	☐ No
Are you currently pregnant or trying to get pregnant?	☐ Yes	☐ No
Are you allergic to lidocaine?	☐ Yes	☐ No
Do you get rapid heartbeat with Epinephrine?	☐ Yes	☐ No
Do you get GI issues or yeast infections with antibiotics?	☐ Yes	☐ No
Do friends ever ask if you are tired or sad when you are not?	☐ Yes	☐ No

Smoking Status: (Circle one) Never Smoked Former Smoker Current everyday smoker Unspecified

Drinking Status: (Circle one) None Less than 1 drink per day 1-2 drinks per day 3 or more per day

MEDICATIONS: (PLEASE ENTER ALL CURRENT MEDICATIONS, INCLUDING VITAMINS AND OVER-THE-COUNTER)

Name:	Dose:	Frequency:

ALLERGIES: (PLEASE ENTER ALL ALLERGIES TO MEDICATIONS)

Name:	Reaction:

SIGNATURE:

I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Completed by: ☐ Patient ☐ Patient's Parent ☐ Guardian ☐ Medical Assistant

Print Name: (*if not signed by patient*) _____

X _____ X _____ X _____

Print Patient Name *Signature* *Date*

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HIPAA PRIVACY PATIENT CONSENT FORM:

Our Notice of Privacy Practices provides information about how we may use and disclose protect health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Patient understands that:

- Protected health information may be disclosed or use for treatment, payment or health care operation.
- The Practice has a Notice of Practices, and that the patient had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosure will then cease.
- The Practice may condition treatment upon the execution of this Consent.

X _____ X _____ X _____

Print Patient Name *Signature* *Date*

This Consent was signed by Printed Name – Patient or Representative

RELEASE OF MEDICAL INFORMATION:

Do you authorize our office to discuss your medical information with family members or other individuals? ☐ Yes ☐ No

If Yes, please provide the names and phone numbers below:

Name _____

Relationship _____ Cell Phone: (____) _____

Name _____

Relationship _____ Cell Phone: (____) _____

Please bring this completed form to your first appointment.