Palm Beach Dermatology
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Patient Registration Form

Patient Name:_____ Date of Birth: _____ Age: _____

Local Address:_____
Street City State Zip

Home Phone (____)_____ Cell (____)_____ Work (____)_____

Secondary Address:_____
Street City State Zip

Social Security #:_____ Email: _____

Marital Status (circle one) Single Married Widowed Divorced Separated

Employer: _____Phone: (____)_____

In Case of Emergency Contact: _____ Phone: (____)_____ Relationship _____

Other Family Members Who Are Patients: _____

Referred By:_____
(please circle) Physician Friend Relative Other

Primary Care Physician:_____ Phone: (____)_____

Insured's Responsibility: It is understood that services rendered by the doctor are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of the doctor to collect from the insurance company.

I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to pay the balance promptly. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. All "Insufficient Funds" checks are subject to a $40 service charge. In consideration of any services rendered by Dr. Kishor, Dr. Nolan, Dr. Marsch or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for Dr. Kishor, Dr. Nolan or Dr. Marsch to employ anyone, including a collection agency or attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a $40 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release any referring physician, consultants, as needed and as necessary to process insurance claims, insurance application/prescriptions. I authorize payment of medical benefits to the above physicians listed.

Patient or Responsible Party Signature _____ Date _____

Medical History Form

Patient Name: _____ Age: _____

Reason for visit: _____

Medical History: Have you ever had the following diseases or conditions: (Please check YES or NO)

	Y	N		Y	N		Y	N
Arthritis	__	__	Coronary artery disease	__	__	High cholesterol	__	__
Asthma	__	__	Depression	__	__	Leukemia	__	__
Atrial Fibrillation	__	__	Diabetes	__	__	Lung Cancer	__	__
Bone marrow transplantation	__	__	End stage renal disease	__	__	Lymphoma	__	__
Breast cancer	__	__	Hepatitis	__	__	Seizures	__	__
Colon cancer	__	__	HIV/AIDS	__	__	Stroke	__	__
COPD	__	__	Hypertension	__	__	Thyroid disease	__	__

Surgical History: Have you ever had any surgeries on the following organs: (Please check YES or NO)

	Y	N		Y	N		Y	N
Bladder removed	__	__	Hip replacement	__	__	Mastectomy	__	__
Colectomy: colon cancer resection	__	__	Hysterectomy	__	__	Ovaries removed	__	__
Colectomy: inflammatory bowel	__	__	Kidney stone removal	__	__	Prostate cancer	__	__
Gallbladder removal	__	__	Kidney transplant	__	__	Spleen removal	__	__
Heart: Angioplasty	__	__	Kidney removal	__	__	Testicle removed	__	__
Heart: Bypass surgery	__	__	Knee replacement	__	__	Other: _____		
Heart: Transplant	__	__	Liver removal	__	__			
Heart: Valve replacement	__	__	Lumpectomy	__	__			

Skin Disease: Have you ever had any of the following conditions: (Please check Yes or NO)

	Y	N		Y	N		Y	N
Acne	__	__	Eczema	__	__	Psoriasis	__	__
Actinic keratosis	__	__	Flaking or itching scalp	__	__	Squamous cell skin cancer	__	__
Basal cell skin cancer	__	__	Melanoma	__	__	Other:_____		
Blistering sunburn	__	__	Precancerous moles	__	__			

Skin History:

Do you wear sunscreen? (Circle) YES NO

Do you tan in a tanning salon? (Circle) YES NO

Do you have a family history of melanoma? (Circle) YES NO

If yes, which relative(s)? _____

3/10/2022

Pharmacy:

Name: _____

Street Address: _____

Zip Code: _____

Phone Number: _____

Many pharmacies will submit a list of your current medications directly to the office.
Do you consent to allowing our office to import your pharmacy prescription medications: YES NO
(circle one)

Medications: (Please list all current medication if consent was denied)

_____

_____

_____

Allergies: (Please list all allergies)

_____

_____

Immunizations:

Influenza	Yes	No
Pneumonia	Yes	No
Shingles	Yes	No

Other:

Do you have a living will?	YES	NO
Do you have a health care surrogate?	YES	NO

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked

Quit: former smoker

Smoker (packs/day____, total yrs ____)

Alcohol Use:

None

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

Sexual Activity:

Not sexually active

Sexually active with 1 partner

Sexually active more than 1 partner

Same sex partner

Race: (Circle all that apply)

White

Black/African American

Asian

American Indian or Native American

Ethnicity: (Circle)

Hispanic/Latino

Non-Hispanic/Latino

Preferred languages:

English

Spanish

Other: _____

Systems Review: Do you have any of the following issues: (Please check Yes or NO)

	Y	N		Y	N		Y	N
Problems with bleeding	__	__	Hay fever	__	__	Problems with scarring	__	__
Problems with healing	__	__	Night sweats	__	__	Unintentional weight loss	__	__

Alerts: Do you have any of the following issues: (Please check YES or NO)

	Y	N		Y	N		Y	N
HIV Positive	__	__	Allery: Adhesive	__	__	MRSA	__	__
Hep C positive	__	__	Allergy: Lidocaine	__	__	Pacemaker	__	__
Epi sensitivity	__	__	Allergy: Topical antibiotic	__	__	Premed prior to procedure	__	__
Taking Plavix	__	__	Artificial heart valve	__	__	Rapid heartbeat with epi	__	__
Taking Coumadin	__	__	Artificial joint (past 2 yrs)	__	__	Pregnant or planning to		
Taking Aspirin	__	__	Blood thinners	__	__	become pregnant	__	__
Taking Xarelto	__	__	Defibrillator	__	__			

Family History: Describe any family history (only immediate relatives)

_____

_____

_____

_____

Completed by: ___ Patient Signature: _____ Date: _____/_____/_____

___ Parent Print name: _____

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

PBD&P, Inc.

I, _____ have been given the opportunity to read a copy of the PBD&P's Notice of Patient Privacy Practices.

_____ _____

Signature of Patient or Parent or Legal Guardian

Date

Please Check One:

_____ I hereby authorize this medical practice to contact me by telephone and if I am not present, a message may be left on my answering machine or voicemail.

_____ Do NOT leave messages on my answering machine or voicemail other than the name of the caller and the telephone number.

Other Contact Information:

The following person other than a guardian or conservator is authorized to discuss my medical condition or billing information with a healthcare professional on this practice:

_____

Name Relationship Phone Number

_____

Patient Signature Date

_____

Print name Phone number

The above authorization can be revoked at anytime in writing.

3/10/2022