Palm Beach Dermatology
4475 Medical Center Way, Suite 2
West Palm Beach, Fl. 33407-3240

Phone: 561-863-1000
Fax: 561-863-1319

Patient Registration Form

Patient Name:_____ Date of Birth:_____ Age _____

Local Address: _____
Street City State Zip

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

Out of Town Address: _____ Out of Town Phone ( )_____
Street City State Zip

Sex: male female

Social Security #: _____

Marital Status (circle one) S M W D Sep Spouse Name_____ Birthdate _____

Occupation: _____

Employer's Address: _____ Phone ( )_____
Street City State Zip

In Case Of Emergency Contact:_____ Phone ( )_____ Relationship _____

Other Family Members Who Are Patients: _____

Referred By: _____
Physician, Friend, Relative, Other

Primary Care Physician: _____

Address: _____ Phone ( )_____
Street City State Zip

Pharmacy of Choice:_____ Phone ( )_____

Insurance

Name of Insured: _____ Social Security # or ID #: _____

Name of Insurance: _____ Phone ( )_____ Group #: _____

Address of Insurance Company: _____
Street City State Zip

If Student (circle one): Full Time Part Time Name of School _____

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 in full promptly.

I clearly understand and agree that all services rendered me 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 Palm Beach Dermatology 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 Palm Beach Dermatology 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 to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Palm Beach Dermatology.

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
Anxiety	_	_	Depression	_	_	Hypothyroidism	_	_
Arthritis	_	_	Diabetes	_	_	Leukemia	_	_
Asthma	_	_	End stage renal disease	_	_	Lung cancer	_	_
Atrial fibrillation	_	_	GERD	_	_	Lymphoma	_	_
Bone marrow transplantation	_	_	Hearing loss	_	_	Prostate cancer	_	_
Benign prostatic hyperplasia	_	_	Hepatitis	_	_	Radiation treatment	_	_
Breast cancer	_	_	Hypertension	_	_	Seizures	_	_
Colon cancer	_	_	HIV/AIDS	_	_	Stroke	_	_
COPD	_	_	High cholesterol	_	_	Other _____		
Coronary artery disease	_	_	Hyperthyroidism	_	_			

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

	Y	N		Y	N		Y	N
Appendix Removed	_	_	Heart: Mechanical valve	_	_	Ovaries removed: cyst	_	_
Bladder removed	_	_	Heart: Angioplasty	_	_	Ovaries: tubal ligation	_	_
Breast biopsy	_	_	Hip replacement (both)	_	_	Pancreas removed	_	_
Lumpectomy (both breasts)	_	_	Hip replacement (left)	_	_	Prostate biopsy	_	_
Lumpectomy (left breast)	_	_	Hip replacement (right)	_	_	Prostate cancer	_	_
Lumpectomy (right breast)	_	_	Knee replacement (both)	_	_	Prostate removal for BPH	_	_
Mastectomy (both breasts)	_	_	Knee Replacement (left)	_	_	Rectum resection APR	_	_
Mastectomy (left breast)	_	_	Knee Replacement (right)	_	_	Rectum resection low anterior	_	_
Mastectomy (right breast)	_	_	Kidney biopsy	_	_	Skin: basal cell carcinoma	_	_
Colectomy: colon cancer resection	_	_	Kidney stone removal	_	_	Skin: melanoma	_	_
Colectomy: diverticulitis	_	_	Kidney transplant	_	_	Skin: biopsy	_	_
Colectomy: inflammatory bowel	_	_	Kidney removal	_	_	Skin: squamous cell carcinoma	_	_
Colon: colostomy	_	_	Liver removal	_	_	Spleen removed	_	_
Gallbladder removal	_	_	Liver transplant	_	_	Testicle removed	_	_
Heart: biologic valve replacement	_	_	Liver shunt	_	_	Hysterectomy: fibroids	_	_
Heart: bypass surgery	_	_	Ovaries removed: endometriosis	_	_	Hysterectomy: uterine cancer	_	_
Heart: Transplant	_	_	Ovaries removed: cancer	_	_	Hysterectomy: cervical cancer	_	_

Other _____

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

	Y	N		Y	N		Y	N
Acne	_	_	Dry skin	_	_	Poison ivy	_	_
Actinic keratosis	_	_	Eczema	_	_	Precancerous moles	_	_
Asthma	_	_	Flaking or itching scalp	_	_	Psoriasis	_	_
Basal cell skin cancer	_	_	Hayfever/allergies	_	_	Squamous cell skin cancer	_	_
Blistering sunburns	_	_	Melanoma	_	_	Other _____		

Skin History:

Do you wear sunscreen? (Circle) Yes No
If yes, what SPF? _____
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)? _____

Medications: (Please list all current medications)

_____
_____
_____

Allergies: (Please list all allergies)

_____
_____

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 with 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 language

English
Spanish
Other

Other:

Do you drive during the day? Yes No
Do you drive at night? Yes No
How often do you exercise? _____
Describe your caffeine use: _____
If you are over 65, how many times in the past year have you had 5 or more alcoholic drinks for men or 4 or more drinks for women? _____
Occupation and Workplace: _____
Place of Residence: _____

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

	Y	N		Y	N		Y	N
Problems with bleeding	_	_	Unintentional weight loss	_	_	Neck stiffness	_	_
Problems with healing	_	_	Thyroid problems	_	_	Headaches	_	_
Problems with scarring	_	_	Sore throat	_	_	Seizures	_	_
Rash	_	_	Blurry vision	_	_	Cough	_	_
Immunosuppression	_	_	Abdominal pain	_	_	Shortness of breath	_	_
Hay fever	_	_	Bloody stool	_	_	Wheezing	_	_
Chest pain	_	_	Bloody urine	_	_	Anxiety	_	_
Fever or chills	_	_	Joint aches	_	_	Wheezing	_	_
Night sweats	_	_	Muscle weakness	_	_	Other _____		

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

	Y	N		Y	N		Y	N
HIV Positive	_	_	Allergy: 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 become pregnant	_	_
Taking Aspirin	_	_	Blood thinners	_	_	West Africa travel	_	_
Taking Xarelto	_	_	Defibrillator	_	_	Risk of Ebola	_	_

Family History: Describe any family history (only first degree relatives)

_____

_____

_____

Pharmacy:

Name: _____

Street address: _____

Zip Code: _____

Phone Number: _____

Do you consent to allowing our office to import your pharmacy prescriptions medications ☐ Yes ☐ No

Completed by: ☐ Patient

☐ Parent

Signature: _____ _____/_____/_____ Date

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 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 in this practice:

_____

Name Relationship Phone number

_____

Patient signature Date

_____

Print name Phone number

The above authorization can be revoked at anytime in writing.