Patient Information Sheet

Account No. __________
Physician __________
Date __________

PLEASE PRINT

Name of Patient ____ Age __________
(Last) (First) (Middle)

Date of Birth ____________________ SS# ______________________ Sex ________ Marital Status _______________

Mailing Address ____
(Street/PO Box) (Apt #) (City) (State) (Zip)

Best Daytime Contact Phone Number	**Evening Phone Number**	**Alternate Phone Number**
______________________	______________________	______________________
☐ **Cell** ☐ **Home** ☐ **Work**	☐ **Cell** ☐ **Home** ☐ **Work**	☐ **Cell** ☐ **Home** ☐ **Work**

Email Address ____

Emergency Contact (not living with you) ____
(Name) (Relationship) (Phone Number)

Primary Care Physician ____
(Name) (City/State)

Occupation/Previous Occupation ______________________________________ Retired: ☐ Yes ☐ No

Patient's Employer ____
(If child, give parents information) (Name) (City/State)

The Federal Government requests that we collect the following information:

Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Type-Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Type-Unknown **Preferred Language:** ____________________________

It is the policy of this practice to collect payment at time of service.

Primary Insurance (please circle) **Policy #**____________________________________
FL Blue Cross/Shield PPC/PPO Medicare Coventry Health Care Capital Health Plan United Health Care Other________________

Secondary Insurance (please circle) **Policy #** ____________________________________
FL Blue Cross/Shield PPC/PPO Medicare Coventry Health Care Capital Health Plan United Health Care Other________________

Name of Policy Holder: __________________________________ **Policy Holder Date of Birth:** ________________

OVER

Dermatology Associates OF TALLAHASSEE

MEDICAL HISTORY

Do you have any of the following health problems? **Please check all that apply.**

- ☐ Basal/ Squamous Cell Skin Cancer
- ☐ Melanoma Skin Cancer
- ☐ Atypical Moles
- ☐ Sun Sensitivity
- ☐ Dry/Sensitive Skin
- ☐ Cancer (Non-Skin Cancer)
- ☐ Psychiatric Problems
- ☐ Diabetes
- ☐ Hepatitis B/C
- ☐ HIV
- ☐ Tuberculosis
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Taking Blood Thinners
- ☐ Joint replacement or hardware
- ☐ Lupus
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Organ transplant
- ☐ Stroke
- ☐ Heart Attack

Are you pregnant? ☐ Yes ☐ No **If yes, notify nurse**

Current smoking status: ☐ Smoke every day ☐ Smoke sometimes ☐ Former smoker ☐ Never smoked

ALLERGIES: Are you allergic to any medications? ☐ Yes ☐ No **If yes, list medication and the reaction you had:**

____

____

CURRENT MEDICATIONS: (list all medications and dosage you take on a regular basis or every once in a while):

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

OTHER MAJOR MEDICAL PROBLEMS/ OPERATIONS/ HOSPITALIZATIONS:______________________

____

____

REASON FOR SEEING DOCTOR TODAY: ______________________________________

____

____

Have you sought care for this problem elsewhere? ☐ Yes ☐ No If yes, where? ______________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS FOR PHYSICIANS.

COMMERCIAL INSURANCE

I hereby authorize the release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO DERMATOLOGY ASSOCIATES OF TALLAHASSEE. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature (patient or guardian) ______________________________________

MEDICARE INSURANCE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Associates of Tallahassee for any services furnished to me by Dermatology Associates of Tallahassee. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services.

Signature (patient or guardian) ______________________________________

Name: ______________________________________ Date:______________

Medication History Patient Consent

I agree that Dermatology Associates of Tallahassee may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

___________________________________ _______________
Patient Signature Date

Pharmacy Information:

Pharmacy Name: ____

Street: ______________________________ City: ______________________

Phone Number: (If you know it) ______________________________

Dermatology Associates OF TALLAHASSEE

MRN:___________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that I received the Notice of Privacy Practices from Dermatology Associates of Tallahassee, which sets forth the ways in which my personal health information may be used or disclosed by Dermatology Associates of Tallahassee Physicians, and outlines my rights with respect to such information.

____
Patient signature

____
Date

PHONE CONTACT AUTHORIZATION

Your signature authorizes Dermatology Associates to disclose your personal health information in the following manner:

Voice mail at home: Yes No

Voice mail at work: Yes No

Also please list the individuals with whom we may discuss your information:

Name	Relationship	Phone Number

I understand that I may revoke this authorization by contacting Dermatology Associates in writing.

Print name	Signature	Date