2018 PATIENT INFORMATION SHEET - PLEASE PRINT

DERMATOLOGY CONSULTANTS OF SOUTH FLORIDA, P.A.

FOR INTERNAL USE ONLY
DOCTOR
PATIENT NO.
DATE

WELCOME TO OUR OFFICE: The confidential information below is important for our records.

NAME: LAST | FIRST | AGE

LOCAL ADDRESS | APT. NO | ADDRESS OUT OF STATE | APT. NO.

CITY | STATE | ZIP | CITY | STATE | ZIP

PHONE NO. (PREFERRED) ( ) | PHONE NO. (ALTERNATE) ( )

DATE OF BIRTH | SEX ☐ M ☐ F | SPOUSE'S NAME

NAME OF NON-MEDICAL EMERGENCY CONTACT | PHONE NO. ( ) | CELL NO. ( )

NAME OF HEALTH INSURANCE | PRIMARY POLICYHOLDER/SUBSCRIBER

PRIMARY DOCTOR | PHONE NO. ( ) | REFERRED BY: ☐ FAMILY FRIEND ☐ INSURANCE COMPANY ☐ YELLOW PAGES ☐ INTERNET ☐ SELF/OTHER

REFERRING PHYSICIAN (IF DIFFERENT FROM PRIMARY DOCTOR) | PHONE NO. ( )

IF MINOR: NAME OF PARENT OR LEGAL GUARDIAN | PHONE NO. ( ) | CELL NO. ( )

RELEASES · CONSENTS · ACKNOWLEDGEMENTS

______ Please Initial

ACKNOWLEDGED RECEIPT OF NOTICE OF PRIVACY PRACTICE:
I acknowledge that I have received a copy of Dermatology Consultants of South Florida, P.A. Notice of Privacy Practices.

______ Please Initial

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize Dermatology Consultants of South Florida to release to my insurance company, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I authorize and request my insurance company to pay directly to the above named doctor the amount due in my pending claim. I understand I am financially responsible for all charges not covered by this authorization and guarantee payment of this account.

______ Please Initial

EMAIL ADDRESS: ____________________
I, additionally give Dermatology Consultants of South Florida P.A. permission to email me Appointment Confirmations and information about any alerts, specials, promotions and/or educational informative seminars at their offices or at their medspa, Spa Cosmedica and Laser Center.

______ Please Initial

PHYSICIAN ASSISTANT: I agree to be seen by a Physician Assistant (PA-C).

Date: ____________ **SIGN HERE:** ____________________
Patient or Legal Guardian

PLEASE COMPLETE THE REVERSE SIDE

HISTORY

Do you have an personal history of any of the following illnesses:

☐ High Blood Pressure ☐ Diabetes ☐ Ulcer ☐ Heart Disease ☐ Kidney Disease

☐ Liver Disease ☐ Thyroid Disease ☐ Rheumatic Fever ☐ Asthma ☐ Hay Fever

☐ Eczema ☐ Allergies ☐ Tuberculosis ☐ Colitis ☐ Cancer

☐ Other_______________ ☐ Alcoholism ☐ Substance Abuse

PLEASE LIST ALL MAJOR OPERATIONS:

CURRENT MEDICATIONS

DO YOU WEAR A PACEMAKER? ☐ YES ☐ NO

Are you allergic to any of the following drugs:

☐ Penicillin ☐ Sulfa ☐ Mycins ☐ Anesthetic (Novocaine)

☐ Other Drugs:_______________

HAVE YOU NOTICED A CHANGE (SIZE/COLOR) OF A GROWTH OR MOLE ON YOUR BODY? ☐ YES ☐ NO

Is there any family history of:

☐ Hay Fever ☐ Eczema ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Cancer

Please provide the information below. We greatly appreciate your participation.

1. Pharmacy information. Please indicate the pharmacy you would like us to send any needed prescriptions to.

Pharmacy Name:_______________ Phone #:_______________

Address: _______________ City:_______________

2. Occupation: _______________

3. Smoking History. Please check one box below.

☐ Active Smoker ☐ Former Smoker ☐ Never Smoked ☐ Unknown

4. Race. Please mark the ONE statement that best describes you.

☐ American Indian or Alaska Native ☐ Multiracial ☐ White

☐ Asian ☐ Native Hawaiian ☐ Other Race

☐ Black or African American ☐ Other Pacific Islander ☐ I prefer not to answer

5. Language. Please indicate your preferred spoken language.

☐ English ☐ Other: _______________

☐ Spanish ☐ I prefer not to answer

6. Ethnicity. Please mark the ONE statement that best describes you.

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I prefer not to answer