DERMATOLOGY CENTER
OF THE PALM BEACHES

Today's date: _____

Patient Information (Please print clearly)

Name: _____
Last First M.I.

Date of Birth: _____ Age:_____ Sex: ☐ Male ☐ Female

Mailing address: _____
Address City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

Parents or Guardian (if patient is a minor)

Mother: _____
Last First Phone Number

Father: _____
Last First Phone Number

Other Guardian: _____
Last First Phone Number
Relationship:_____

Insurance Subscriber (if other than the patient)

Name: _____ Date of birth: _____
Last First M.I.

***Please present your insurance card(s) and a photo ID to the receptionist along with this completed form thank you.

5808 Jog Rd, Lake Worth, FL 33467 – Phone: 561.968.7546 – Fax: 561.968.1143

DERMATOLOGY CENTER
OF THE PALM BEACHES

Emergency Contact Name & Relationship:_____ Phone Number:_____
Primary Care Physician: _____ Phone number: _____

Do you have any of the following?

	Y	N		Y	N
Autoimmune disease	☐	☐	Cancer (breast, lung, colon, prostate, etc)	☐	☐
Family history of melanoma Who? _____	☐	☐	Skin cancer	☐	☐

☐ basal cell ☐ melanoma

☐ squamous cell ☐ other

☐ unsure what type

Major surgery (please list) _____
_____

Major medical problems:

	Y	N		Y	N
Arthritis	☐	☐	Epilepsy	☐	☐
Anxiety disorder	☐	☐	Gastroesophageal reflux disease	☐	☐
Asthma	☐	☐	Hearing loss	☐	☐
Atrial fibrillation	☐	☐	Hepatitis C	☐	☐
Benign prostatic hyperplasia	☐	☐	Hypertension	☐	☐
Cerebrovascular accident (stroke)	☐	☐	Hyperthyroidism	☐	☐
Chronic obstructive lung disease	☐	☐	Hypothyroidism	☐	☐
Coronary arteriosclerosis	☐	☐	Human immunodeficiency virus	☐	☐
COVID-19	☐	☐	Hypercholesterolemia	☐	☐
Depressive disorder	☐	☐	Inflammatory disease of liver	☐	☐
Diabetes mellitus	☐	☐	Transplantation of bone marrow	☐	☐
End-stage renal disease	☐	☐			

If any history of acne, eczema or psoriasis, what medications have you used?
_____

Current Medications (Prescription, OTC, Supplements) ***OMIT IF YOU BROUGHT PRESCRIPTION LIST***

_____
_____
_____

☐ No prescriptions, OTC, supplements

Allergies (Medications, Food, etc.) ***PLEASE LIST ITEM AND DESCRIBE REACTION YOU GET***

_____
_____

☐ No known allergies

Social History

Tobacco use: Current Former Never

Do you have a healthcare proxy? (i.e., someone who can make decisions your behalf) ☐ Yes ☐ No
If yes, what is their name and phone number? _____

Do you have any of the following conditions which would affect the way we care for you?

	Y	N		Y	N
Fainting with procedures	☐	☐	Pacemaker	☐	☐
Problems with bleeding	☐	☐	Defibrillator	☐	☐
Pregnancy, or planning pregnancy	☐	☐			

What are you seeing us for?

What are your concerns today? _____

Did another clinician refer you for this? ☐ Yes ☐ No If yes, what is their name? _____

Pharmacy: _____Address: _____Phone number: _____

Height: _____ Weight: _____

HIPAA PATIENT CONSENT FORM

Our notice of Privacy Practice Act Provides information about how we use and disclose your protected health information. The notice contains a patient's rights section describing your rights under the law. You have the right to review our Notice before signing the 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 revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosure 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 their protected health information may be disclosed or used for treatment, payment, or health care operations. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice. The practice reserves the right to change the notice of privacy practices. The patient has the right to restrict the use 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 receipt of treatment upon execution of this consent.

PATIENTS RIGHTS OF DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communication of health information made by alternative means. Communication with the practice using email, fax and cell phone are not guaranteed to be secure or confidential. If these methods are initiated below, I waive the practice's obligation to ensure confidentiality. I also understand that email and fax are not appropriate means of communication or emergencies.

Communication Authorization Exception

How would you like to be contacted by us?

I, _____, (patients first and last name) wish to be contacted in the following manner:

(Please Check box and initial ALL preferential methods of contact)

Home #__ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**
Cell #__ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**
Work #__ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**
Email Address __ Okay to leave detailed message __ Leave message with call back number only **Initial:_____**
Mail to home address ____ **Initial:_____**
Fax Home # _____ **Initial:_____** **Patient's Date of Birth:_____**
Work Fax # _____ **Initial:_____**

I allow the release of my health information to the following people: (please print names clearly)

Name	**Relationship**
_____	_____
_____	_____

Patient Name or Guardian Name (Please print) **Sign & Date**

_____ _____

DERMATOLOGY CENTER
OF THE PALM BEACHES

****YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY****

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is the responsibility of the patient to understand their individual coverage and its limitations, as well as the providers accepted by the plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred.

Insurance policies are a contract between the patient and the carrier. It is the responsibility of the patient to know which providers are in their specific network.

Financial Responsibility: Patients are financially responsible for all charges, whether paid by their insurance for all services rendered on their behalf or dependent's behalf.

Payment: Any and all co-pays, co-insurance, deductibles and account balances are due at the times of service.

Balances: Balances outstanding for more than 90 days will be subject to collection fees (at the patient's expense) and may be referred to a collection agency.

Referral/Authorizations: If the patient's health insurance policy requires a referral/authorization, it is the patient's responsibility to obtain it prior to the scheduled appointment. Since most insurances will deny wellness visits for Dermatologists.

Lab Fees: Please be advised that all specimens (biopsy, cultures, etc…) will be sent to an independent lab to be processed and you might receive a separate bill from that lab. **INITIAL:_____**

Returned Check Policy: A fee of $50 will be charged for each check that is returned (subject to change).

I certify that all the insurance information that I have provided is current and correct. I authorize Dermatology Center of the Palm Beaches to administer medical care as deemed necessary. I authorize the release of any medical information requested by my insurance carrier in order to process insurance claims. I understand that I am personally responsible for all fees, Including deductibles, co-pays and co-insurance incurred for services rendered to be or dependent. I authorize payment of insurance benefits paid on my behalf, to be made directly to Dermatology Center of the Palm Beaches. I authorize Dermatology Center of the Palm Beaches to release medical information to a 3rd party or its agents.

I certify that I have read this form in its entirety and will abide by the above policies.

Print Patient Name:_____ DOB:_____ Date:_____

Patients Signature (or other legally Authorized Persons):_____