DERMATOLOGY GROUP P.A

JEFFREY S. GREENWALD, M.D. • MICHAEL S. HENNER, M.D. • ROBERT W. DEMETRIUS, M.D. • KEMKA S. OGBURIA, M.D.
DINAH M. WARNER, M.D. • KATHLEEN B. ZENDELL, M.D. • STEVEN M. PRICE, M.D.
EDWARD J. POSNAK, M.D. • ASHLEY R. VRECENAK PA-C, MPAS . • MICHELLE T. SNIDER PA-C, MPAS

2850 Morningside Drive, Mount Dora, Florida 32757 • (352) 383-0733
515 W. S.R. 434 Suite 210, Longwood, Florida 32750 • (407) 332-8080
300 E. Hazel Street Orlando, Florida 32804 • (407) 898-3033

Date: _____ **Please Type or Print Clearly** **Chart #:** _____

PATIENT INFORMATION

Legal Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____
(Last) (First) (Middle)

Date of Birth: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female **SSN:** _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Child **Student Status:** ☐ Full Time ☐ Part Time

Mailing Address: _____
(Include Street, City, State and Zip)

Home Phone: _____ **Work:** _____ **Cell:** _____
(Include Extension, if applicable) (OK to Text ☐)

Email Address: _____ **How did you hear about us?** _____

☐ Spouse ☐ Parent ☐ Guardian **Name:** _____

Patient's Occupation: _____ **Employer or School:** _____

Family Physician: _____ **Address:** _____

Address: _____ **Phone:** _____

Referred by: _____

Have you or anyone in your immediate family been a patient in any of our offices before? ☐ Yes ☐ No If yes, list:

Name: _____ Relationship: _____ Which Office? _____ When? _____

PERSON RESPONSIBLE FOR BILL

Legal Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____
(Last) (First) (Middle)

Relationship to Patient: _____ **Gender:** ☐ Male ☐ Female **SSN:** _____

Address: _____
(Include Street, City, State and Zip)

Mailing Address (if different from above): _____
(Include Street, City, State and Zip)

Home Phone: _____ **Work:** _____ **Cell:** _____
(Include Extension, if applicable) (OK to Text ☐)

Employer of Responsible Party: _____

Person to contact in case of emergency other than spouse: _____

Address: _____ **Phone:** _____

How may we contact you regarding appointments, follow-up, biopsy results, lab results, etc.?

May we contact you...: at home? ☐ Y ☐ N on your cell? ☐ Y ☐ N at your place of employment? ☐ Y ☐ N

May we leave a voice-message at/on...: your home? ☐ Y ☐ N your cell? ☐ Y ☐ N place of employment? ☐ Y ☐ N

May we discuss your medical condition with a member of your household? ☐ Y ☐ N

If yes, whom: _____ Relationship: _____

I hereby give consent to The Dermatology Group, P.A. to provide the necessary treatment by the assigned physician. I am aware that the pathology service for evaluation and diagnosis of tissue specimen is interpreted by Dr. Michael S. Henner. This service may result in a separate co-pay/bill as determined by your insurance company. I am aware that payment is expected at the time service is rendered. By supplying my email address above, I give permission to The Dermatology Group to contact me via email.

Signature: _____ **Date:** _____

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Patient Authorization to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided with a "*Notice of Privacy Practices*" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the **"*Notice"*** prior to acknowledging this authorization,
- The right to restrict or revoke the use of disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Restrictions:
I request the following restrictions to the use of disclosure of my health information:

_____

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare options:
(example: spouse, children, other relatives, friends, or caregivers)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

What is your preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Text ☐ Email

I understand that as part of treatment, payment, or healthcare options, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I authorize such disclosure for these uses as permitted by law.

I fully understand and ☐ **accept** ☐ **decline** the information of this authorization.

_____ _____
Patient/Guardian Signature **Print Name of Person Signing**

*If other than patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare options? ☐ Yes ☐ No

_____
Date

****
FOR OFFICE USE ONLY

☐ "Authorization form" signature refused by patient ☐ Restrictions added by patient

☐ "Authorization form" placed in the patient's medical record on: _____

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Financial Policy, Please Read

BASIC POLICY: Payment for service is due in full at the time service is provided in our office. Accounts that have balances more than 90 days past due may possibly be turned over to a collection agency unless previous arrangements have been made.

FOR PATIENTS WITH INSURANCE: We will bill contracted insurance carriers if proper and correct information is provided. Because of various time limits, insurance information must be filled correctly the first time. If incorrect information is given, then the patient will be responsible for payment in full. Copayments, Coinsurance, and/or Deductibles are due at the time of service.

MEDICARE: The Dermatology Group P.A. Accepts assignment on all Medicare claims. We will also bill the secondary insurance companies that we are contracted with for you. If no secondary insurance information is provided, patients will be responsible for 20% of the Medicare allowable charge at the time of service. Any Copayments, Coinsurance, and/or Deductibles are due at the time of service.

NON-COVERED SERVICES: Any service not paid for by your existing insurance coverage will require payment in full at the time services are provided. These services are usually considered Cosmetic and will be discussed prior to being performed.

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insured Name:		**Insured Name:**	
Date of Birth:	**SSN:**	**Date of Birth:**	**SSN:**
Insurance:		**Insurance:**	
ID#:	**Group#:**	**ID#:**	**Group#:**
Address:		**Address:**	
Employer:		**Employer:**	

Your Signature Will Serve For Any or All of the Following:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier and independent laboratories any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or to the party who accepts assignment, Regulation pertaining to Medicare assignment of benefits apply.

AUTHORIZATION OF MEDICAL RELEASE AND PAYMENT: We only file insurance claims to plans in which we participate. If you are not covered by one of the insurance plans that we participate in, then payment is expected at the time of service. I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to the physician. If insurance does not pay, I will become financially responsible for payment in full. I permit a copy of these authorizations to be used in place of this original which is on file at the physician's office.

LIFETIME SIGNATURE AUTHORIZATION FOR MEDICARE: I authorize the release of any medical information necessary to process a claim. I also request payment benefits either to myself or to the party who accepts assignment.

LIFETIME SIGNATURE AUTHORIZATION FOR MEDIGAP: I request that payment of authorized Medigap benefits be made on my behalf to The Dermatology Group, P.A. for any services furnished by The Dermatology Group, P.A. I authorize any holder of medical information about me to release to the above Medigap carrier any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

If signed by Legal Representative, Relationship to Patient **Date**

the DERMATOLOGY GROUP P.A

Medical History Form

Patient Name: _____ **Date:** _____ **Acct:** _____
(For Office Use Only)

PATIENT DEMOGRAPHICS

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Preferred Language:** _____

Race (Please check one):

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race

Ethnic Group (Please check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Chronic Lung Disease)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

☐ Other: _____

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy ☐ Right ☐ Left
- ☐ Lumpectomy ☐ Right ☐ Left
- ☐ Breast Biopsy
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA (Angioplasty)
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Knee Replacement ☐ Right ☐ Left
- ☐ Hip Replacement ☐ Right ☐ Left
- ☐ Kidney Biopsy
- ☐ Kidney Removed ☐ Right ☐ Left
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Surgery)
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed ☐ Right ☐ Left
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

☐ Other: _____

Patient Name: _____ **Date:** _____ **Acct:** _____
(For Office Use Only)

SKIN DISEASE HISTORY (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None

☐ Other: _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Any other family history: _____

PHARMACY & MEDICATIONS (Please enter all current medications, dosage and frequency)

Pharmacy Name: _____ Phone #: _____ Address: _____

Medication / Dosage / Frequency	Medication / Dosage / Frequency

☐ None

ALLERGIES (Please enter all allergies)

☐ None

Patient Name: _____ **Date:** _____ **MRN:** _____
(For Office Use Only)

SOCIAL HISTORY (Please check all that apply)

Alcohol Use:

- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Cigarette Smoking:

- ☐ Never smoked
- ☐ Quit: Former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check all that apply)

- ☐ Allergy to Adhesive
- ☐ Blood Thinners
- ☐ Pregnancy or Planning a Pregnancy
- ☐ Swollen Lymph Nodes
- ☐ Problems with Bleeding
- ☐ Problems with Healing
- ☐ Problems with Scarring (Hypertrophic or Keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Thyroid Problems
- ☐ Sore Throat
- ☐ Blurry Vision
- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Anxiety
- ☐ Depression

☐ Other Symptoms: _____

☐ None

ALERTS: Are you currently experiencing any of the following? (Please check all that apply)

- ☐ Allergy to Lidocaine
- ☐ Allergy to topical Antibiotic Ointment
- ☐ Artificial Heart Valve
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Premedication prior to procedure
- ☐ Rapid Heartbeat with Epinephrine

☐ Other: _____

☐ None

Cosmetic Intake Form

Please complete this questionnaire if you have any cosmetic concerns or interest in any of the cosmetic services that we offer

Name: _____ Email: _____

By supplying my email address above, I give permission to The Dermatology Group to contact me via email.

Would you like us to contact you if we are running any sales/promotions? Yes/No

Do you have any of the following:

- Wrinkles on your face?
  - ☐ Forehead/Brow
  - ☐ Crows Feet
  - ☐ Cheeks
  - ☐ Around the mouth
    - ☐ Are you interested in Botox?
    - ☐ Are you interested in Fillers?
    - ☐ Are you interested in laser resurfacing?
    - ☐ Are you interested in medicated creams/cosmeceuticals?

- Brown spots on your skin?
  - ☐ Are you interested in light treatment (IPL)?
  - ☐ Are you interested in medicated creams (retinoids/hydroquinone)?
  - ☐ Are you interested in chemical peels?

- Red spots/dilated blood vessels/rosacea?
  - ☐ Are you interested in light treatment (IPL)?
  - ☐ Are you interested in medicated creams/cosmeceuticals?

- Loss of eyelashes?
  - ☐ Are you interested in Latisse?

- General skin care questions?
  - ☐ Are you interested in facials?
  - ☐ Are you interested in extractions?
  - ☐ Are you interested in skin care products?