



JEFFREY S. GREENWALD, M.D. • MICHAEL S. HENNER, M.D. • ROBERT W. DEMETRIUS, M.D. • KEMKA S. OGBURIA, M.D.
KATHLEEN B. ZENDELL, M.D. • DINAH M. WARNER, M.D. • EDWARD J. POSNAK, M.D. • MELIA H. HOLT, M.D.
SAQIB R. AHMED, M.D. • ALFREDO E. GONZALEZ, M.D. • ASHLEY R. VRECENAK PA-C, MPAS • MICHELLE T. SNIDER PA-C

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 201 N. Lakemont Ave Suite 800, Winter Park, FL 32792 • (407) 645-2737

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

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)

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

PAST SURGICAL HISTORY (Please check all that apply)

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

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

SKIN DISEASE HISTORY (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever / Allergies | <input type="checkbox"/> None |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Melanoma | |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Poison Ivy | |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Precancerous Moles | |
| <input type="checkbox"/> 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)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Pregnancy or Planning a Pregnancy | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Swollen Lymph Nodes | <input type="checkbox"/> Unintentional Weight Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Problems with Bleeding | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Problems with Healing | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Problems with Scarring
(Hypertrophic or Keloid) | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Bloody Urine | |
| <input type="checkbox"/> Other Symptoms: _____ | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> None | | |

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

- | | |
|---|---|
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to topical Antibiotic Ointment | <input type="checkbox"/> Premedication prior to procedure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Rapid Heartbeat with Epinephrine |
| <input type="checkbox"/> Defibrillator | |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> None | |