PATIENT REGISTRATION

TEL :(941) 282-3376 (DERM)
FAX: (941) 282-3378

Today's Date ____/____/____

Name (First, Middle, Last)______________________________ **DOB**____________________

Mailing Address____
STREET / PO BOX CITY STATE ZIP CODE

Secondary Address ____
STREET / PO BOX CITY STATE ZIP CODE

Home Phone____________________ **Cell Phone**____________________ **Gender** ☐ Male ☐ Female

Work Phone ______________________________

Race ☐ White ☐ Asian ☐ Black or African American ☐ Other Race

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to specify

Preferred language ☐ English ☐ Spanish ☐ Other

Emergency Contact Name: ____________________ **Relationship:**__________**Phone** __________

Can we discuss your Health Care Information with the person listed above? ☐ **YES** ☐ **NO**

Should we contact YOU by phone at: Home ☐ **Work** ☐ **Either** ☐ **Cell Phone** ☐

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Separated

Spouse's Name______________________________Spouse's Number____________________

If Patient Is A Minor Or Student

Mother's Name & Surname ____________________Date of Birth ____________________
Address____
Home Phone ____________________ Cell Phone____________________

Father's Name & Surname____________________Date of Birth____________________
Address____
Home Phone____________________Cell Phone____________________

Person Responsible for Payment, If Not Above
Name______________________________**Home Phone** ____________________
Address____

Parent, Guardian, Custodian, or General Agent authorizing and consenting to medical treatment:

☐ ______________________________ ☐ ______________________________
Signature / Date Printed Name

INSURANCE INFORMATION

Patient Name (First, Middle, Last)______________________________________ Date_________________________

Primary Carrier ____Phone #______________________

Carrier's Address____
Street City State Zip Code

Insured (Policy Holder) ____________________________________Date of Birth______________________________

Relationship to Patient ____

Insured ID #____

Secondary Carrier ____Phone #______________________

Carrier's Address____
Street City State Zip Code

Insured (Policy Holder) ____________________________________Date of Birth______________________________

Relationship to Patient ____

Insured ID #____

Please complete this form and bring to your appointment with **Insurance card(s)** and **Driver's License** as well as your **medication list** if applicable. Payment for all professional services is expected at the time services are rendered, unless alternative arrangements have been made in advance. All deductibles and co-payments must be paid at the time of the office visit. We accept cash, credit card and checks.

Our office files claims for Medicare assignment and any managed care plans and commercial plans with which we participate. I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

I have completed this form fully, and I certify that I am the patient, or the general agent or legal guardian of the patient duly authorized to furnish the information requested.

Services provided for a minor are the responsibility of the accompanying adult, regardless of custodial status.

NOTE: If you have an HMO plan, you are responsible for obtaining an Authorization from your primary care physician prior to your visit or we may have to reschedule your appointment.

____ ________________________

Patient or Guardian Signature **Date**

Sunshine State DERMATOLOGY AND SKIN CANCER CENTER

PATIENT HEALTH INFORMATION

Patient Name________________________________ **DOB** ______________________________

Primary Pharmacy ____ **Phone #**________________

Did a Physician refer you to our practice? ☐YES ☐ NO

If yes, please supply the name of the **Referring Physician Name:**______________ Phone:______________

Primary Care Physician Name:________________________________ Phone:______________

List **ALL MEDICATIONS** you are currently taking (including over the counter products, medications or supplements)

MEDICATION NAME	STRENGTH	HOW MANY TIMES A DAY

List **ALL** drug or environmental allergies

MEDICAL HISTORY

Select any of the following medical conditions you currently have or have had them in the past;

- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Asthma / COPD
- ☐ BPH (Prostate) / Prostate Cancer
- ☐ Cancer: Breast, Colon, Kidney, Lung
- ☐ Heart /Coronary Artery Disease
- ☐ Diabetes
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure (Hypertension)
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyper/Hypothyroidism
- ☐ Leukemia/Lymphoma
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Rheumatic Diseases (Lupus, Sjogren's etc)
- ☐ ________________

Family Members history of Melanoma?____

Do you wear sunscreen? ☐ YES ☐ NO Do you tan in tanning salon? ☐ YES ☐ NO

Drink alcohol? ☐ YES ☐ NO Do you smoke? ☐ YES ☐ NO

WOMEN ONLY

Are you or might you be pregnant? ☐ YES ☐ NO

Are you planning to become pregnant in the near future? ☐ YES ☐ NO

Are you on Birth Control Pills? ☐ YES ☐ NO

Sunshine State DERMATOLOGY AND SKIN CANCER CENTER

PAST SURGICAL HISTORY

Please circle if you have any of the following currently or have had them in the past:

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Biopsy/Lumpectomy/Mastectomy
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon: Inflammatory Bowel Disease/Colostomy
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Bypass Surgery/Valve Replacement
- ☐ Joint Replacement: Knee (☐ Left/ ☐ Right)
- ☐ Joint Replacement: Hip (☐ Left/ ☐ Right)
- ☐ Kidney: Kidney Biopsy/Nephrectomy
- ☐ Ovaries: Endometriosis/Cysts/Cancer
- ☐ Ovaries: Tubal Ligation/Hysterectomy
- ☐ Prostate: Biopsy/TURP
- ☐ Spleen (Splenectomy)
- ☐ Transplant: Heart/Kidney/Liver/Lung
- ☐ Testicles (Orchiectomy)
- ☐ Uterus: Uterine or Cervical Cancer
- ☐ Other
- ☐
- ☐

CHECK ALL THAT CURRENTLY APPLY

- ☐Allergy to lidocaine/Epinephrine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial joints withing past 2 years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ Allergy to adhesive or latex
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Pregnant, planning or nursing

Please list any other pertinent health information____

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SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratoses (Pre Cancers)
- ☐ Basal Cell Carcinoma
- ☐ Dysplastic nevus of the skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma Date/ Location
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other

Have you completed a PDT (blue light therapy treatment) in the past? ☐ YES ☐ NO Date: ___________

Have you had fluorouracil (Efudex) topical treatment in the past? ☐ YES ☐ NO Date: ____________