

2012 PATIENT INFORMATION SHEET - PLEASE PRINT

FOR INTERNAL USE ONLY

**DERMATOLOGY CONSULTANTS
OF SOUTH FLORIDA, P.A.**

DOCTOR

PATIENT NO.

DATE

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

NAME: LAST FIRST M.I. AGE

STREET ADDRESS

CITY STATE ZIP APT. NO.

PHONE NO. (PRIMARY) () PHONE NO. (SECONDARY) () PHONE NO. (OTHER) ()

DATE OF BIRTH SEX M F SOCIAL SECURITY NO. SPOUSE'S NAME

PRIMARY CARE PHYSICIAN & OFFICE PHONE NO. OFFICE PHONE NO. ()

NAME OF EMERGENCY CONTACT PHONE NO. () CELL NO. ()

PREFERRED PHARMACY NAME ADDRESS OR LOCATION OF PHARMACY PHARMACY PHONE NO. ()

NAME OF HEALTH INSURANCE POLICYHOLDER NAME

REFERRING DOCTOR PHONE NO. () REFERRED BY: FAMILY INSURANCE COMPANY FRIEND INTERNET OTHER

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

RELEASES • CONSENTS • ACKNOWLEDGEMENTS

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 MEDICAL INFORMATION:

I hereby authorize the release of my medical information to:

Name/Relationship to Patient (spouse, family member, etc.)

Phone No. _____

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.

Please Initial

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

Please Initial

EMAIL ADDRESS: _____

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

Please Initial

Date: _____

SIGN HERE: _____

Patient or Legal Guardian

PLEASE COMPLETE THE REVERSE SIDE

HISTORY

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

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Smoking | <input type="checkbox"/> 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:

- | | | | |
|---|--------------------------------|---------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Mycins | <input type="checkbox"/> Anesthetic (Novocaine) |
| <input type="checkbox"/> Other Drugs: _____ | | | |

HAVE YOU EVER HAD X-RAY
THERAPY FOR A MALIGNANCY
OR SKIN CONDITION?

- YES NO

HAVE YOU NOTICED A CHANGE
(SIZE/COLOR) OF A GROWTH OR
MOLE ON YOUR BODY?

- YES NO

Is there any family history of:

- | | | | | | |
|------------------------------------|---------------------------------|---------------------------------|------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Eczema | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
|------------------------------------|---------------------------------|---------------------------------|------------------------------------|-----------------------------------|---------------------------------|