

## *Brandon Dermatology Patient Information*

Name (Last, First, MI) \_\_\_\_\_ Male  Female   
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( \_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_ ) \_\_\_\_\_  
Driver's license # \_\_\_\_\_ St \_\_\_\_\_ Marital status \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Have any of your family members been seen here before? Y / N If yes, Name \_\_\_\_\_

If patient above is not the policyholder, please complete below:

Policy Holder Name (Last, First, MI) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relation to Patient \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Employer \_\_\_\_\_ Work Phone ( \_\_\_\_ ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

To notify in case of emergency: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone ( \_\_\_\_ ) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_

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### *Insurance Information*

Private/Self Pay     HMO     PPO     Medicare

#### **PRIMARY:**

Insurance Company \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Claims Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( \_\_\_\_ ) \_\_\_\_\_

#### *SECONDARY: (IF APPLICABLE)*

Insurance Company \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Claims Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( \_\_\_\_ ) \_\_\_\_\_

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or authorized  
representative \_\_\_\_\_

**New Patient Notice of Privacy**  
**And Disclosure of Health Information**

I understand that as a part of my healthcare, Brandon Dermatology, P.A. and its physician(s) originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that as part of this organization's treatment, payment, and health care operations, it may become necessary to disclose my protected health information to another entity associated with my medical care. I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The complete Private Policy Notice of Brandon Dermatology and its physician(s) is available in the office for my perusal. I may also request my own copy if I desire.

**I fully understand and accept the terms of this consent.**

Patient Name(print) \_\_\_\_\_ Date \_\_\_\_\_  
Patient Signature \_\_\_\_\_  
Parent or Authorized representative (if applicable) \_\_\_\_\_

Please complete the following information:

**Name of person(s) with whom we may discuss your medical information (i.e. wife/husband, child, etc)**

Name _____	Relation _____
Name _____	Relation _____
Name _____	Relation _____

**May we leave a message on your answering machine of the following:**

Upcoming scheduled appointments     yes     no  
Normal laboratory/ pathology results     yes     no

**BRANDON DERMATOLOGY, PA**

**Statement of financial Responsibility & Release of Information**

**1. Payment and Release of Information:**

I hereby assume responsibility to pay to the costs of all services provided by Brandon Dermatology, P.A. and its physician(s) to the patient. My signature below signifies my understanding and willingness to comply with this policy. All payments are due at the time services are rendered unless prior arrangements have been made. There will be a \$25 charge for all returned checks. I agree I may be charged a 1.5% interest rate per month and collection fees on any unpaid balances for which I am responsible.

**Name of patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Patient** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_

**2. HMO / PPO / Commercial Insurance:**

I understand that Brandon Dermatology, P.A. and its physician(s) will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Brandon Dermatology, P.A. and its physician(s) of medical benefits, for the services provided. I understand that I am financially responsible for my health **insurance deductibles, coinsurance, and non-covered services**. I also understand that I am responsible for all necessary referrals if indicated by my insurance plan.

**Name of patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Patient** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_

**3. Medicare ONLY:**

Lifetime Authorization:

I Certify that the information given by me in applying for payment under Title XVIII and/or Title, of the Social Security Act is correct, and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediary carriers, any information needed for their or related Medicare claim. I hereby irrevocably assign payment to Brandon Dermatology and its physician(s) accepting assignment of all medical benefits applicable and otherwise payable to me. I also understand that Medicare will cover 80% of covered charges and I will be responsible for the other 20% unless covered by an additional insurance.

**Signature as it appears on card** \_\_\_\_\_ **Date** \_\_\_\_\_

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release or he above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

**Signature as it appears on card** \_\_\_\_\_ **Date** \_\_\_\_\_

## BRANDON DERMATOLOGY MEDICAL HISTORY

Patient: \_\_\_\_\_ Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_  
 (Last) (First) (M.I.)

**Personal History :** (Please check all appropriate boxes)

Chicken pox	yes <input type="checkbox"/>	no <input type="checkbox"/>	Thyroid disease	yes <input type="checkbox"/>	no <input type="checkbox"/>	Aids/HIV	yes <input type="checkbox"/>	no <input type="checkbox"/>
Asthma	yes <input type="checkbox"/>	no <input type="checkbox"/>	Kidney disease	yes <input type="checkbox"/>	no <input type="checkbox"/>	Syphilis	yes <input type="checkbox"/>	no <input type="checkbox"/>
Rheumatic fever	yes <input type="checkbox"/>	no <input type="checkbox"/>	Bleeding disorder	yes <input type="checkbox"/>	no <input type="checkbox"/>	Herpes/cold sores	yes <input type="checkbox"/>	no <input type="checkbox"/>
Arrhythmia	yes <input type="checkbox"/>	no <input type="checkbox"/>	Anemia	yes <input type="checkbox"/>	no <input type="checkbox"/>	Venereal disease	yes <input type="checkbox"/>	no <input type="checkbox"/>
High blood pressure	yes <input type="checkbox"/>	no <input type="checkbox"/>	Eye disorder	yes <input type="checkbox"/>	no <input type="checkbox"/>	Keloids	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart murmur	yes <input type="checkbox"/>	no <input type="checkbox"/>	Depression	yes <input type="checkbox"/>	no <input type="checkbox"/>	Eczema	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart surgery	yes <input type="checkbox"/>	no <input type="checkbox"/>	Arthritis/Joint pain	yes <input type="checkbox"/>	no <input type="checkbox"/>	Skin infections	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart valve surgery	yes <input type="checkbox"/>	no <input type="checkbox"/>	Meningitis	yes <input type="checkbox"/>	no <input type="checkbox"/>	Shingles	yes <input type="checkbox"/>	no <input type="checkbox"/>
Mitral valve prolapse	yes <input type="checkbox"/>	no <input type="checkbox"/>	Migraine headaches	yes <input type="checkbox"/>	no <input type="checkbox"/>	Liver disease	yes <input type="checkbox"/>	no <input type="checkbox"/>
Pacemaker	yes <input type="checkbox"/>	no <input type="checkbox"/>	Epilepsy/Seizures	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hepatitis	yes <input type="checkbox"/>	no <input type="checkbox"/>
Artificial joint	yes <input type="checkbox"/>	no <input type="checkbox"/>	Gastric ulcers	yes <input type="checkbox"/>	no <input type="checkbox"/>	Diabetes	yes <input type="checkbox"/>	no <input type="checkbox"/>
Tuberculosis	yes <input type="checkbox"/>	no <input type="checkbox"/>	Chron's/Colitis	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hives	yes <input type="checkbox"/>	no <input type="checkbox"/>
COPD/Emphysema	yes <input type="checkbox"/>	no <input type="checkbox"/>	Other _____					

**Skin History:**

Has anyone in your family had skin cancer?      yes  no       If yes, what type: \_\_\_\_\_  
 Any history of any skin disease?      yes  no       If yes, please list: \_\_\_\_\_  
 Do you heal slowly?      yes  no       Do you bleed easily or have prolonged bleeding?      yes  no   
 Do you take antibiotics prior to dental cleaning?      yes  no

**Medications:** (Please list all medicines including aspirin, birth control pills, vitamins/supplements, diet pills, etc)

**Allergies to medications:**      yes       no       If yes, please list medication (s) and what happens: \_\_\_\_\_

Allergies to Novacaine	yes <input type="checkbox"/>	no <input type="checkbox"/>	If yes, what happens? _____
Latex	yes <input type="checkbox"/>	no <input type="checkbox"/>	If yes, what happens? _____
Lidocaine	yes <input type="checkbox"/>	no <input type="checkbox"/>	If yes, what happens? _____
Tape/Baindaid	yes <input type="checkbox"/>	no <input type="checkbox"/>	If yes, what happens? _____
Anesthetic (local/general)	yes <input type="checkbox"/>	no <input type="checkbox"/>	If yes, what happens? _____

**Surgery:** (list all) \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

**Social History:**

Alcohol?      yes       no   
 Smoke ?      yes       no   
 Snuff/smokeless tobacco ?      yes       no   
 Recreational drugs?      yes       no

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Women:** (Please complete)

First day of last menstrual cycle \_\_\_\_\_ Pregnant      yes  no       Breast-feeding      yes  no

How did you hear about our practice \_\_\_\_\_ Referred by: \_\_\_\_\_

I hereby acknowledge that all of the above information is accurate and complete to the best of my ability

**Patiente Name:** \_\_\_\_\_ **Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Parent or authorized representative \_\_\_\_\_