Name: ____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: ______ SS#: ______________________ Sex: ☐ Male ☐ Female

Race: ___________________ Ethnicity: _________________ Primary Language Spoken: _________________

Mailing Address: ____
City *State* *Zip Code*

Phone:(_____)____________________________ Work Phone: (_____)________________________________

Cell Phone:(_____)________________________ E-mail: ____

Referred by:____ Phone (_____)__________________________

Occupation: ____

Marital Status: ☐Single ☐Married ☐Separated ☐Domestic Partner ☐Widowed ☐Divorced

Primary Care Physician____

Referring Doc: ____

Phone (_____)__________________________

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?_______________________ Phone (_____)________________

Relationship to patient: ____

Do you give our office permission to discuss your medical information with family members?

☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name: _____________________________________ Relationship: ___________________________

Phone # (day): (_____)_______________________ Phone # (evening): (_____)________________

May we leave personal medical information on your answering machine or cell phone?

☐ YES ☐ NO If yes, what number do you prefer that we use? (____)__________________________

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: ____Date of Birth: ____/____/____
Last *First* *M.I.*

Address:____
City *State* *Zip*

Home Phone: (____)_______________________ SS#________________________________

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance 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 myself or the party who accepts assignment.

Signature: ____ Date: ____/____/____

FLIP OVER→→→

Financial Policy

Thank you for choosing Suncoast Skin Solutions for your dermatologic and surgical needs. We are committed to providing you with quality care and to do so we have initiated the following policies:

- If your health insurance plan has contracted with our office, we will gladly file your claim; however, we do require co-payment, deductible, payment for non-covered services, and any percent responsibility you have under your plan at the time of your visit. If our office is not contracted with your health insurance plan, payment for the total cost of your visit is expected at the time of service. We can provide you with a paid receipt so that you may submit it for reimbursement. We accept cash, checks, Discover, Visa, and Master Cards. If you are unable to pay, please notify the receptionist prior to your visit and make the necessary arrangements.

- In order to file medical services with your insurance carrier, we ask the following:
  - We need a copy of your insurance card.
  - We need to verify active coverage and benefits at the time services are rendered. If we cannot verify benefits prior to your visit, then we will need to reschedule your visit or pay out-of-pocket and submit the claim to your insurance company for reimbursement.
  - We need accurate, up to date insurance information. Please notify us of any changes.
  - You need to be familiar with your medical insurance benefits. It is your responsibility to understand your insurance coverage for common visits and charges, failure to do so may result in more out-of-pocket expenses. If an authorization is required by your insurance company you are responsible for bringing that to your appointments, otherwise this may result in denied claims that you will be responsible for. If there is something you do not understand please ask prior to your visit so that we can clarify what your responsibility will be.
- For Medicare patients, Medicare will pay 80 percent of the approved amount directly to us. If you do not have a participating secondary insurance, you will be expected to pay the remaining 20 percent at the time of service, as well as any unmet deductible and any non-covered service. We can provide you with a paid receipt so that you may submit it for reimbursement.
- If you do not have medical coverage, we are able to offer our services at a discounted rate, as long as the charges are paid in full at the time of the visit.
- Fees:
  - **There will be a $25 fee if you fail to provide 24-hour notice of your intent to not keep your appointment**.
  - We provide medical records to other physicians at no charge. However, if you request your entire medical record a charge will apply, in accordance to Florida guidelines.
  - There is a $10.00 fee for filling out forms. (disability, FMLA, etc).
  - For all returned checks there is a $35.00 fee. We will not be able to accept another check until the returned check and fees are paid in full.

Suncoast Skin Solutions, Inc. is fully compliant with the Health Insurance Portability and Accountability Act of 1996 (HIP *AA).* Our manual of Privacy Practices is available for your review in our waiting areas and a copy will be provided to you at your request. By signing this form you acknowledge that you have been made aware that you have certain rights under HIPAA. Your signature does not waive any of those rights.

I understand that all professional services rendered are charged to the patient (or guardian). ***I fully agree that the responsibility for prompt payment for the services rendered is mine***. I understand that interest charges will be added monthly to all unpaid balances at the rate of 1.5% per month. I will also assume the responsibility for any collection or attorney fees related to satisfying this account.

Patient Name:____

Signature:____ Date: ______________________

PATIENT NAME:____DOB:______________________________WEIGHT:_________

Primary Care Physician:______________________________________ Referring Physician: _______________________________

Reason for today's visit: ____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. Please list all known drug allergies.____

2. Please list all medications you are currently taking.

____

____

3. Have you ever had any operations? Yes No If yes, please describe. ____

____

4. Have you ever been treated for any of the following (**please circle Yes or No for each**, **if Yes, please explain**):

a.	Constitutional Symptoms *(weight loss/gain, fever, etc.)*	Yes	No	______________________
b.	Eye Disorders	Yes	No	______________________
c.	Ear, Nose, Throat, and Mouth	Yes	No	______________________
d.	Respiratory Disorders (lung disease)	Yes	No	______________________
e.	Digestive Diseases	Yes	No	______________________
f.	Urinary/Bladder/Kidney Disease	Yes	No	______________________
g.	Blood Disorders	Yes	No	______________________
h.	Muscle/Skeletal Disorders	Yes	No	______________________
i.	Skin Disorders	Yes	No	______________________
j.	Neurologic Disorders	Yes	No	______________________
k.	Psychiatric	Yes	No	______________________
l.	Endocrine (diabetes, thyroid, etc.)	Yes	No	______________________
m.	Cardiovascular *(high blood pressure, heart disease)*	Yes	No	______________________
n.	Cancer	Yes	No	______________________
o.	Allergic/Immunologic	Yes	No	______________________
p.	Scarring (keloids, etc.)	Yes	No	______________________
q.	Hepatitis or HIV	Yes	No	______________________
r.	Advanced Care (Surrogate)	Yes	No	______________________
s.	History of Flu Vaccine	Yes	No	______________________
t.	History of Malignant Melanoma	Yes	No	______________________
u.	History of Pneumonia Vaccine	Yes	No	______________________

5. Do you routinely *require antibiotics prior* to dental/surgical procedures due to a heart murmur, artificial heart valve, artificial joint, etc.? Yes No

6. Do you take an anticoagulant, such as Coumadin, Plavix, or Aspirin (please circle if applicable)? Yes No

7. Do you smoke or chew Tobacco? Yes No If former smoker then specify start/end date: _________

Specify current/past per day: _______ cigarettes/packs/dip/cigars/chew: ______________

8. Do you drink Alcohol? Yes No

If yes, how many alcoholic beverages do you consume daily: 1-3: ________ 4-6: _________ 7-10: _______ 10+:______

9. Do you have a history of Skin cancer? Yes No BCC SCC MM Abnormal Moles Other_________

Do you have a Family history of Skin cancer? Yes No BCC SCC MM Abnormal Moles Other________

10. Do you have a history of Skin disease? Yes No Please Specify______________________________________

Do you have a Family history of Skin disease? Yes No Please Specify__________________________________

11. Sun exposure: o Daily o Weekly o Rarely o Use of sunblock o History of tanning bed use

12. FOR WOMEN ONLY: a. Are you pregnant or currently planning a pregnancy? Yes or No

b. Are you currently nursing? Yes or No

13. **Family History** (please specify disease and family member) Unknown Adopted

a. Autoimmune disorders ____

b. Colon Cancer____

c. Diabetes____

d. Glaucoma____

e. High blood pressure____

f. High cholesterol____

g. Liver disease____

h. Lung disease____

i. Malignant Melanoma____

j. Obesity____

k. Premature Coronary Heart Disease____

l. Skin cancer____

m. Thyroid disease____

Pharmacy Information

Preferred Pharmacy:_______________________ Phone Number: (___)_______________

Address:____