



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 Physician: _____

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: ____/____/____



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: _____ HEIGHT: _____ 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
<i>(weight loss/gain, fever, etc.)</i> | 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
<i>(high blood pressure, heart disease)</i> | 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. PATIENTS 65 AND OLDER

Do you have an advanced care plan/directive?

- Yes - You wish to list your Surrogate Decision Maker: _____
- Yes - You do not wish to indicate Surrogate Decision Maker.
- No

14. **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: _____