

Curtis Dermatology, P.A.

10817 S. Jog Road, Suite #236 • Boynton Beach, Florida 33437 • (561) 777-7703 • (561) 777-7704

PATIENT INFORMATION

Date _____ E-mail Address _____

Patient Name _____ Age _____ Date of Birth _____
First Middle Last

SS# _____
 Married Widowed Male
 Single Divorced Female

Local Address _____ Home Phone _____
Apt. No. City State Zip

Permanent Address _____ Cell Phone _____
Apt. No. City State Zip Work Phone _____

Person to Pay Bill _____ Relationship _____
Address _____ Work Phone _____

Race _____ Cell Phone _____

Which do you consider yourself? _____ Hispanic or Latino _____ Not Hispanic or Non-Latino
Which language do you prefer to use to communicate? _____ English _____ Spanish _____ Other

Name of SPOUSE (or PARENT) _____ SS# _____

PATIENT Employer _____ Occupation _____ Work Phone _____
Address _____

SPOUSE / PARENT Employer _____ Work Phone _____
Address _____

To Notify in Case of Emergency _____ Relationship _____ Phone _____

Referred by _____

Primary Insurance _____ Secondary Insurance _____

Pharmacy _____ Address / Cross Streets _____ Phone _____

Consent to Release My Medical Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), I give my permission for Curtis Dermatology, P.A. to call the **designated number(s) and leave a detailed message** on voicemail, or in person, in reference to any items that assist the practice including but not limited to, appointment reminders, insurance items, account collection, queries concerning missed or cancelled appointments, test results, medical condition and/or my clinical care.

Patient Signature _____ Printed Name _____ Date _____

Number(s) to call (Circle: Cell, Home, Work, Other)

I hereby give permission for the person(s) listed below to receive any of my lab results and/or to discuss my medical condition.

Name(s): _____ Phone # _____

Name(s): _____ Phone # _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

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NEW PATIENT HISTORY

Name (Printed): _____ Date of Birth: _____ Age: _____

Please Check the Boxes Below for Any Conditions You Have or Have Ever Had

- | | | |
|--|--|--|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Allergies / Hay Fever | <input type="checkbox"/> <input type="checkbox"/> Hip / Knee / Joint Surgery | <input type="checkbox"/> <input type="checkbox"/> Substance / Alcohol Abuse |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> <input type="checkbox"/> Serious Infection |
| <input type="checkbox"/> <input type="checkbox"/> COPD / TB | <input type="checkbox"/> <input type="checkbox"/> Kidney / Urinary Disease | <input type="checkbox"/> <input type="checkbox"/> Herpes / STD / Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> A Fib | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> HIV+ |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> <input type="checkbox"/> Pacemaker / Defibrillator | <input type="checkbox"/> <input type="checkbox"/> Leukemia or Lymphoma | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> <input type="checkbox"/> Heart Valve / Murmur | <input type="checkbox"/> <input type="checkbox"/> Large Change in Weight | <input type="checkbox"/> <input type="checkbox"/> Changing Mole/ Dysplastic Mole |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Cancer (not skin) _____ | <input type="checkbox"/> <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> <input type="checkbox"/> Endocarditis | <input type="checkbox"/> <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> <input type="checkbox"/> Nail Fungus / Nail Disease |
| <input type="checkbox"/> <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> <input type="checkbox"/> BPH | <input type="checkbox"/> <input type="checkbox"/> Liver Disease / Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Eczema |
| <input type="checkbox"/> <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> <input type="checkbox"/> Stomach Ulcer / Heartburn | <input type="checkbox"/> <input type="checkbox"/> Recurrent Blisters (Mouth /Skin) |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Recent Hospitalization / Surgery | <input type="checkbox"/> <input type="checkbox"/> Keloid Scars |
| <input type="checkbox"/> <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> <input type="checkbox"/> Headache (severe/recurrent) | <input type="checkbox"/> <input type="checkbox"/> Skin Cancer (BCC / SCC) |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> <input type="checkbox"/> Skin Cancer (Melanoma) |
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> <input type="checkbox"/> Seizure/Neurological Disease | <input type="checkbox"/> <input type="checkbox"/> Family History of Skin Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Lupus / Scleroderma | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> <input type="checkbox"/> Skin Disease Not Listed |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint Pain | <input type="checkbox"/> <input type="checkbox"/> Cataracts / Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Taken Accutane in Last Year |

Do you have Advanced Directive/Living Will? Yes No Surrogate: _____

Have you received a flu shot this year? Yes No Taking Hormones/Birth Control? Yes No

Pneumonia Vaccine (>65 years old)? Yes No Planning Pregnancy, Pregnant or Nursing? Yes No

Explain "Yes" to Medical Conditions and List any Other Medical Problems Not Listed Above: _____

Any Family history of Diabetes, Heart Disease or Cancers (including skin)? (List first degree relatives only): _____

Do You Take Antibiotics Before Dental Work or Surgical Procedures? Yes No Rx: _____

Do You Drink Alcohol? Yes No If Yes, _____ Drink(s) per Week _____ Occasionally

Do You Smoke? Yes No Past use If Yes, _____ Pack(s) per Day _____ Occasionally

Are You Allergic To: Adhesive Antibiotic Ointment Epinephrine Iodine Latex Lidocaine

Do You Have Any other ALLERGIES to MEDICATION? Yes No

Please list Medication Name and Reaction:

Please List All Prescription and Over-the-Counter Medications You Take: _____

Do you wear sunscreen Yes No Any tanning bed use? Yes Past use Never

Who Referred You to Our Office? _____

Primary Physician: _____ Phone Number: _____

I declare that I have read the foregoing and the answers are true to the best of my knowledge. I also consent to be evaluated and treated by the healthcare provider.

Patient / Guardian Signature: _____ **Date:** _____

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RELEASE OF INFORMATION & MEDICAL TREATMENT

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize Curtis Dermatology, P.A. to release to my insurance carrier and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process the claim.

I request that the payment of authorized benefits be made on my behalf. I hereby assign the benefits payable for physician services to Curtis Dermatology, P.A. and authorize Curtis Dermatology, P.A. to submit my claim to my health insurance carrier (including Medicare) for payment of medical services rendered to me. This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned.

I also understand that any portion of the fee not paid by my insurance carrier/company (including deductibles) will become my personal obligation and will be paid promptly by me. I understand that I am responsible for obtaining referrals and authorizations from my insurance carrier. Failure to do so may result in my being billed for the unauthorized procedure. I also understand that if my account is placed with an outside collection agency, I will be responsible for any and all collection fees. I understand that any procedure in addition to the office visit will incur additional charges, such as laboratory work; any lab work that will be sent out to an independent/outside laboratory will be billed to me directly by the Lab Company and not by Curtis Dermatology, P.A.

I understand that Curtis Dermatology enforces a No Show and Late Cancellation Policy in which I will be responsible for paying a \$25 fee if an appointment is not cancelled within the allowed 24 hours.

I authorize my signature to be placed "on file" for the purpose of Medicare and insurance claim form submission.

I acknowledge full responsibility for payment of services rendered and agree to pay for them in full, at the time of service, unless other arrangements have been made in advance with this office.

I also give my permission to Curtis Dermatology, P.A. and to the physician furnishing the services for any treatment necessary. Under the penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

Patient / Guardian Signature

_____ Date

INSURANCE ASSIGNMENT AGREEMENT/PRIVACY NOTICE ACKNOWLEDGEMENT

****PLEASE SIGN THE RELEASE BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE****

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____

Name of Insurance Company (ies)

_____, and assign directly to Curtis Dermatology, P.A. all insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize Curtis Dermatology, P.A. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Beneficiary/Patient Signature

_____ Relationship

_____ Date

MEDICARE Lifetime Authorization. Medicare patient certification. Patient certification authorization to release information and payment request.

I certify that the information given by me in applying for payment under Title XVII and /or Title XIX of the Social Security Act if correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature

_____ Print Patient Name

_____ Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Signature

_____ Print Patient Name

_____ Date

_____ Parent or Authorized Representative (if applicable)