



CENTER FOR DERMATOLOGY  
AND SKIN SURGERY, INC.

**PATIENT INFORMATION**

Please Print

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name

\_\_\_\_\_

Last

First

MI

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Lic # \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation \_\_\_\_\_

Pharmacy of Choice \_\_\_\_\_ Phone \_\_\_\_\_ Date of last physical \_\_\_\_ / \_\_\_\_ / \_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY** (if different from patient)

Name \_\_\_\_\_

Last

First

MI

Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Financial Responsibility Agreement**

I have been informed and understand that I am financially responsible for payment of services at the time of the visit. I also understand that all laboratory charges are billed separately from the physician and are my responsibility to pay.

In the event, my doctor deems any procedure medically necessary for my treatments, but the cost is not covered by my health insurance, I agree to assume full financial responsibility for payment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Continued on back

**Primary Insurance information**

ID/GROUP # \_\_\_\_\_ Effective Date of Coverage \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Company Name / Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance Information**

ID/GROUP # \_\_\_\_\_ Effective Date of Coverage \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Company Name / Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Assignment of Benefits**

I, the undersigned, hereby authorized the above- named medical group to release to my insurance company any medical information acquired to assist in processing any health insurance and / or medical claims for services received from my doctor. I authorize payment of such claims to be permanently assigned to Center for Dermatology and Skin Surgery, Inc. I also understand that I am financially responsible for all charges whether or not paid by the said insurance company.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Informed Consent**

I understand that during my course of treatment, unforeseen conditions may occur that necessitates a skin biopsy(s) to be taken by shave, punch, and / or excision. In addition, I also give permission to have minor surgical procedures and any subsequent treatments as deemed necessary as long as the risks and complications are discussed with me prior to the said procedure. These risks include, but are not limited to, scarring, bleeding, swelling, pain, deformity, infection, and / or ulceration. I will also inform the dermatologic practitioner of any possible contradictions to the planned procedure, including medications, such as anticoagulants, aspirin, cardiac, infectious or psychotropic.

I recognize that every surgical procedure involves uncertainty and no result can be guaranteed. I also recognize that the practitioner is not responsible for natural complications that may occur. If any postoperative complications occur, it is my responsibility to contact the practitioner as soon as possible.

To document and follow the course of my treatment, I give permission to have photographs taken. Photographs are part of my medical record and are confidential in nature. I also grant permission for the judicious use for medical education purposes if my identity is withheld.

I also consent to the disposal of any tissue, which is removed in accordance with accustomed practice and procedure. I give my permission to have any tissue removed during the procedure sent for histologic examination.

I understand that any controversy or claim arising out of medical care provided will be resolved through mandatory binding arbitration under the rules of the Florida Arbitration Code.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Center for Dermatology and Skin Surgery, Inc.**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye color: \_\_\_\_\_ Hair color: \_\_\_\_\_

**Do you have, or have you ever had, any of the following:**

**Neuro/Head:** Headaches, strokes, seizures \_\_\_\_\_

**Chest/Heart:** Angina, heart attack, mitral valve prolapse, artificial heart valve, bypass, CHF \_\_\_\_\_

**Hypertension** (high blood pressure): \_\_\_\_\_

**Lungs:** Emphysema, bronchitis, asthma, TB \_\_\_\_\_

**Stomach:** Hepatitis, ulcers \_\_\_\_\_

**Endocrine:** Diabetes, thyroid \_\_\_\_\_

**GU:** Prostate \_\_\_\_\_

**Joints:** Arthritis, swelling, hip or knee replacement: \_\_\_\_\_

**Blood:** Anemia, bruise or bleed easily \_\_\_\_\_

**Immunocompromised:** HIV, AIDS \_\_\_\_\_

**Nerves:** Facial weakness, paralysis \_\_\_\_\_

**Skin:** Skin cancer, fever sores, rashes \_\_\_\_\_

**List surgeries:** \_\_\_\_\_

**Anesthesia:** local or general? \_\_\_\_\_

Do you have a **family** history of skin cancer, skin problems or allergies? \_\_\_\_\_

Do you have a heavy intake of coffee, tea, or alcohol? \_\_\_\_\_

Do you smoke or chew tobacco products? \_\_\_\_\_

List all **aspirin, blood thinners** or **arthritis medication** you take on a **regular** basis:

\_\_\_\_\_

List all **daily** medications, vitamins, and supplements: \_\_\_\_\_

\_\_\_\_\_

List **allergies** to medications: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_



CENTER FOR DERMATOLOGY  
AND SKIN SURGERY, INC.

We continually strive to learn more about our patients so that we may offer full-service quality care. Please help us by completing the following information.  
Thank you.

Name \_\_\_\_\_ Date \_\_\_\_\_

PRACTICE LOCATION

- HUDSON     NTH TAMPA     NEW PORT RICHEY     STH TAMPA     SPRING HILL

Please tell us how you heard about us:

- My friend / relative \_\_\_\_\_ recommended the doctor.  
 My Doctor \_\_\_\_\_ referred me.  
 I noticed an ad in \_\_\_\_\_.  
 I found this practice through my insurance provider manual or online listing.  
 TV / Commercial \_\_\_\_\_.  
 Other (please specify) \_\_\_\_\_.

Please checkmark any of the following services that you have an interest in and would like to receive more information about:

- |  |  |
|--|--|
| <input type="checkbox"/> Tattoo Removal                        | <input type="checkbox"/> Psoriasis                   |
| <input type="checkbox"/> Hair loss treatment (Propecia)        | <input type="checkbox"/> Botox                       |
| <input type="checkbox"/> Laser Hair Reduction                  | <input type="checkbox"/> Glycolic Peels              |
| <input type="checkbox"/> Laser resurfacing                     | <input type="checkbox"/> Nail Problems               |
| <input type="checkbox"/> Spider veins of the legs or face      | <input type="checkbox"/> MD Forte™ cosmetic products |
| <input type="checkbox"/> Nlite Laser for facial rejuvenation   | <input type="checkbox"/> Obagi™ cosmetic products    |
| <input type="checkbox"/> Dermal Fillers (Restylane, Collagen)  | <input type="checkbox"/> Microdermabrasion           |
| <input type="checkbox"/> Acne                                  | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Skin Cancer Prevention and Treatments |  |

May we contact you in the future regarding any of the services you have indicated above?  
If so, how would you prefer to be contacted?

- By mail, my address is \_\_\_\_\_  
\_\_\_\_\_  
 By e-mail, my e-mail address is \_\_\_\_\_

DESIGNATION OF ALTERNATIVE COMMUNICATIONS  
CENTER FOR DERMATOLOGY AND SKIN SURGERY, INC.

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As allowed by HIPAA Privacy Regulations, and as an alternative to a face-to-face meeting, I wish for this office to utilize the following means of communicating to me my Protected Health Information (any information regarding your private health):

**Mailing Address**

If appropriate, you may contact me by mail at the following address:

\_\_\_\_\_

**Telephone**

If appropriate, you may contact me by telephone at the following number. You may/may not (please circle one) leave my Protected Health Information on an answering device.

\_\_\_\_\_

**Fax**

If appropriate, you may contact me by fax at the following number:

\_\_\_\_\_

**E-Mail**

If appropriate, you may contact me by E-Mail at the following E-Mail address:

\_\_\_\_\_

**I have the following additional requests for confidential communications regarding my Protected Health Information (such as allowing this office to discuss your Protected Health Information with a family member or friend):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date