THE DERMATOLOGY INSTITUTE
AND SKIN CANCER CENTER

New Patient Questionnaire

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Sex _____

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Ethnicity _____ Pharmacy Name & Number _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact _____ Relationship to Patient _____

Phone _____

R O M MN P

Friend/relative Æ Doctor referral Æ Newspaper ad

I understand that office visit charges are payable on the day service is rendered. I authorize The Dermatology Institute to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between The Dermatology Institute and myself.

Signature _____ **Date** _____

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Intake and History Form

Name: _____ DOB: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____
_____
_____

Past Surgical History

Please list any major surgeries you have had in the past 3 years:

_____

_____

_____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Dry Skin
- ☐ Eczema
- ☐ NONE
- ☐ I l·è CŜØŜ№к ! ffŜ№ΞλŜă
- ☐ [dzLJdză
- ☐ a Ŝfl·y2Y l·
- ☐ tă2№λl·ăλă
- ☐ {ljdzl·Y·2dză / Ŝff / l·yŎŜ№
- ☐ Other

_____

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

_____

_____

Intake and History Form

Medications

List all current medications:

Medication name	Dose (i.e. 10mg)	Frequency (i.e. two pills twice a day)

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Intake and History Form

Review of Systems

Please check yes or no if you CURRENTLY have any of the following:

Symptom	Yes	No
Problems with healing		
Problems with scarring (hypertrophic/keloid)		
Rash		
Problems with bleeding		
Fever or chills		
Cough		
Allergy to adhesive		
Allergy to lidocaine		
Artificial heart valve		
Artificial joints in the past 2 years		
Blood thinners		
Defibrillator		
Pacemaker		
Rapid heartbeat with epinephrine		

Reason for Visit Today

What brings you here today? _____

How long ago did you notice this? _____

Please circle any of the following that pertain to your concern today:

Itchy Bleeding Changing color Changing size Painful Red Scaly Looks different

Getting worse Getting better

Have you tried treating with any prescription or over-the-counter medications? Yes No

If so, which ones: _____

Have you received any of the following immunizations?

Influenza vaccine?: Yes No Pneumonia vaccine? Yes No

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Surgical Procedure Consent Form

During your clinic visits with us, it may be necessary for your dermatology provider to perform various surgical procedures for diagnostic and/or treatment purposes, including but not limited to biopsies, cryosurgery ("freezing"), excision, etc. The reason for the procedure(s), as well as any risks, benefits, and alternatives of the procedure(s) will be discussed with you during your visit. However, we have listed the most common of these risks as follows: scarring, atrophy, recurrence, bleeding, hematoma, seroma, dyspigmentation, redness, pain/discomfort, infection, cosmetic disfigurement, nerve damage or numbness, and loss of function, anesthesia allergy and/or anaphylaxis. You are encouraged to ask your dermatology provider any questions or concerns that you may have prior to the procedure. By signing below, you acknowledge: your understanding of these potential risks, your consent for such dermatologic procedures to be performed during your visits with us, and your consent for photographs to be taken before, during, and after the procedure(s) for your patient chart.

Date: _____

Patient name (printed): _____

Patient/Guardian signature: _____

Provider signature: _____

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Notice of Privacy Practices

USES AND DISCLOSURES

1. During your course of treatment it will be necessary for our practice to share your medical information in the following examples

   - Laboratory Procedures: In order to correctly identify any specimens that we forward to the laboratory, we will need to include your medical information on the laboratory request form.
   - Physician Referral: If we determine that you should be treated by another physician in a different specialty, we will need to forward your medical information to that physician's office.
   - Billing & Collections: In order for our practice to receive payment from your insurance company, we will need to share your medical information with your carrier.

2. On a much less frequent basis, our practice may be required to disclose confidential information with your written consent for the following legal reasons:

   - Uses and disclosures for the public health activities
   - Reporting about victims of abuse, neglect or domestic violence
   - Disclosures for health oversight activities
   - Disclosures for judicial and administrative proceedings
   - Disclosures for law enforcement purposes
   - Uses and disclosures about decedents
   - Disclosures to avert a serious threat to health or safety
   - Uses and disclosures for specialized government functions

3. Any other uses and disclosures of your health information will require your individual written authorization which you may revoke such authorization.

4. On occasion, our employees may contact you at home to provide appointment reminders or information about your treatment.

PATIENT RIGHTS

1. The right to request restrictions on certain uses and disclosures, including a statement that the practice is not required to agree to a requested restriction
2. The right to receive confidential communications
3. The right to inspect and copy protected health information
4. The right to amend protected health information
5. The right to receive an accounting of disclosures of protected health information
6. The right of an individual to obtain a paper copy of this notice from the practice upon request

2783 Brownwood Blvd, The Villages, FL, 32163
Phone: 352-834-7546 | Fax: 352-363-1951 | www.tdiskin.com

MEDICAL PRACTICE DUTIES

1. Our practice is required by law to maintain the privacy of confidential information and to provide our patients with notice of its legal duties and privacy practices with respect to such information
2. Our practice is required to abide by the terms of the notice currently in effect
3. Our practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all confidential information that it maintains. Any revisions to our Privacy Practice Policy will be noted in this Notice with an effective date of such change.

PRIVACY OFFICER
Our Office Manager is the designated Privacy Officer and can be contacted at: (352)-834-7546

PATIENT PRIVACY PREFERENCES:

Please indicate the family member(s) or other person(s), if any, with whom we may discuss your general medical information (i.e. diagnosis, treatments, payments, etc).

Relative's name Phone number

_____ _____

_____ _____

Can confidential messages (i.e. appointment reminders, lab and pathology results, or other health information) be left on your telephone answering machine or voicemail?

Please circle one: YES NO

By signing below, I have read, understand, and agree to the above privacy practices, policies, and preferences:

Patient/Guardian signature _____

Date _____