Welcome to our Practice!

Please provide us with the information below prior to your visit so that we may give you the best service when you arrive. **Questions marked in red are required** for compliance with your insurance company. Please bring copies of your Insurance Cards, Photo ID, Medication List. Thank you for choosing us for your healthcare needs!

Name: ____ Date: _____/_______/________
SS#: ______-________-________ Date of Birth: _____/______/______ Gender (circle) : M F
Marital Status: _________ Employment Status: ___________ Preferred Language: ________

Race/Ethnicity* (circle)

White
Black/African American
Asian
Hawaiian or Pacific Islander
American Indian or Alaska Native
Hispanic
Other: ________________

Address: ____

City: __________________________ State: _________________ Zip: ___________________

Alternate Address: ____

Home Phone: _________________________ Work Phone: ____________________________

Cell Phone: ____________________________ Email Address *: _________________________

Primary Phone preference: Home/Cell/Work May we leave a detailed message? Yes/No

Emergency Contact: __________________________ Phone: ___________________________

Primary Care Physician: _______________________ Referring Physician: ________________

Pharmacy Name: ___________________ Pharmacy Phone: ____________________________

Pharmacy Address or Cross Street: ____

How did you hear about us? Newspaper/Website/Friend/Physician/Insurance/Billboard/Event

Other: _____________________________

YOUR HEALTH HISTORY

Past Medical History (please circle all that apply)

NONE
Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH (Prostate enlargement)
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
Other: _____________
____
____

Past Surgical History: (please circle all that apply)

NONE
Appendix Removed
Bladder Replacement
Mastectomy (right, left, both)
Lumpectomy (right, left, both)
Breast Biopsy (right, left, both)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removal
Coronary Artery Bypass
PTCA (Angioplasty, Stents)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Hysterectomy: (fibroids, Uterine Cancer)
Joint Replacement Knee (right, left, both)
Joint Replacement Hip (right, left, both)
Kidney Biopsy
Kidney Removed (right, left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed:
(Endometriosis, Cyst, Ovarian Cancer)
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Resection)
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Cancer Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (right, left, bilateral)

Skin Disease History (please circle all that apply)

None □

Acne	Flaking or Itchy Scalp	Other: ____________________
Actinic Keratosis	Hay Fever/Allergies	____________________
Asthma	Melanoma	
Basal Cell Skin Cancer	Poison Ivy	
Blistering Sunburns	Precancerous Moles	
Dry Skin	Psoriasis	
Eczema	Squamous Cell Skin Cancer	

Do you wear Sunscreen? YES NO If yes what SPF? _________________

Do You tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO

If Yes which relative? ____

Any other family history of skin disease? ____________________________

Medications (Please enter all current Medications, including non-prescription medications and herbal supplements, or provide a medication list.

Medication	Dosage

Allergies: ____ No Known Allergies ☐

Social History (please circle all that apply)

Cigarette Smoking*: Never smoked / Quit Former Smoker/ Smoke less than Daily/Daily

Other Tobacco Use: Cigar/Pipe/Snuff/Chew

Illicit Drug Use: None/Illicit Drugs/IV Drug use

Alcohol Use*: None/Less than 1 Drink a day/1-2 drinks a day/3 or more drinks a day

Men-How many times in the past year have you had 5 or more drinks in a day? ______

Women-How many times in the past year have you had 4 or more drinks in a day? ______

REQUIRED*

Did you receive the Flu vaccine this year? YES NO

Have you ever received the Pneumonia Vaccine? YES NO

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699 S. Indiana Avenue, Englewood, FL 34223 • Fax: 941.473.0058 • 941.474.8811
www.paradiseherm.com

REVIEW OF SYSTEMS: Please check Yes or No

SYMPTOM	YES	NO
Fever or Chills		
Unintentional Weight Loss		
Night Sweats		
Enlarged Lymph Nodes		
Problems with Bleeding		
Rash		
New or Changing Mole		

Alerts: Please check all that currently apply:

ALERT	YES	NO
Pacemaker		
Defibrillator		
Premedications prior to procedures		
Artificial Heart Valve		
Allergy to Lidocaine		
Rapid Heartbeat with Epinephrine		
Allergy to Adhesive/Tape		
Allergy to Topical Antibiotic Ointments		
Blood Thinners		
MRSA Staph Infection		
Pregnancy or Planning one		
Hospice		

Other things we should be alerted about:

____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

____

This consent was signed by: ____(PRINT NAME PLEASE)

Signature: ____ Date: ________________

Witness: ____ Date: ________________

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CANCELLATION POLICY

We strive to provide excellent care to all patients here at Paradise Dermatology. To do so effectively and efficiently, we have developed a cancellation policy so that we can ensure that those who need access to an appointment are able to be seen in a timely manner.

Our policy is as follows:

1. We require 24 hour notice in the event that you need to reschedule your appointment. For our Sarasota location please call: 941.921.4131, for our Englewood location please call 941.474.8811.

2. If you miss an appointment and do not contact our office 24 hours prior, we will consider this a missed appointment and a **$50.00** no-show charge will be added to your account.
3. Our office makes reminder calls for appointments. Please be sure to keep your contact information up to date with our office so we can ensure that you receive these reminders. ***However, it is ultimately the patient's responsibility to remember their scheduled appointment.***

This fee will be billed to you directly and is not covered by your insurance company. This balance must be paid prior to your next appointment.

I have read and understand the Appointment Cancellation Policy and agree to the terms of this policy.

Signature: ____Date: ____________
Printed Name: ____

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