Office Use Only	
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Mobile • Daphne • Bay Minette • Miramar Beach/Destin • Niceville • Panama City Beach •Panama City
(251) 631-3570 • (850) 502-5989 • Toll Free: 1-855-MyDermDoc (1-855-693-3763)

Date:	**PATIENT INFORMATION**
Patient's **FIRST** Name, MI:	Patient's **LAST** Name:
Mailing Street Address:	Primary Phone #: ( ) Home / Mobile/ Work
City: State: Zip:	Secondary Phone #: ( ) Home / Mobile/ Work
SS#: Marital Status: M / S / D / W	E-mail:
Date of Birth: mm/dd/yyyy Gender: Male/ Female	Preferred Pharmacy's Name:
Employment Status: Full time /Part time/ Ret. / Student / N/A	Pharmacy's Location:
Occupation:	Referred by: Web/Insurance / Family / Friend /NA
Company or School Name:	Did your physician refer you to us? Yes / No
Race: African-American / Asian / Caucasian / Hispanic /Other	Referring Physician: First Name Last Name
Ethnicity: Cuban / Not Hispanic or Lantino / Other:	Primary Care Physician: First Name Last Name
Language: English / Spanish / Other:	Hearing or Vision Impaired: H / V / No
Hospice: Are you currently receiving Hospice Care? Yes / No	Other Disability: No (List, if "Yes":)
EMERGENCY CONTACT:	
Name (First, Last):	Name (First, Last):
Contact#: Rel. to Patient: Spouse / Child / Other	Contact #: Rel. to Patient: Spouse / Child / Other
IF OTHER THAN PATIENT, PERSON RESPONSIBLE FOR ACCOUNT BALANCES -SPOUSE / PARENT / GUARANTOR	
LAST Name:	Rel. to Patient: Spouse / Child / Other_____
FIRST Name, MI:	Primary # Work/Other #:
Employment Status: Full-time / Part-time / Retired / NA	Place of Employment:
Date of Birth: Gender:	Occupation:
INSURANCE INFORMATION REQUIRED:	
Primary Ins. Name:	Co-pay Amt:
Effective Date: Group #:	Cardholder's Relationship to Patient: Self / Spouse / Child / Other
Policy # / Certificate #:	Subscriber's DOB: mm/dd/yyyy
Subscriber's Name:	Subscriber's Sex / Gender: Male / Female
Secondary Ins. Name :	Co-pay Amt:
Effective Date: Group #:	Cardholder's Relationship to Patient: Self / Spouse / Child / Other
Policy # / Certificate #:	Subscriber's DOB: mm/dd/yyyy
Subscriber's Name:	Subscriber's Sex / Gender: Male / Female

RELEASE OF MEDICAL INFORMATION

I, the undersigned as the patient or his/her authorized representative, do hereby authorize Advanced Dermatology, to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim. Advanced Dermatology is also hereby authorized to release to my physician(s), either as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes. I hereby authorize Advanced Dermatology to release any medical information to physicians other than original referring physicians, who may be involved in my or my child's health care treatment, when requested by these physicians. By signing this consent, information will be given to requesting physician without further signed authorization.

I hereby give permission to disclose, (discuss, and speak with) personal medical information about my treatment to the following individuals: Unless specifically listed below, we cannot speak to any individual concerning your medical or financial information including, appointments, test results, prescriptions, school or work excuses, etc. This includes your spouse, children, etc., we must have them listed by name.

RELEASE INFORMATION TO (below)….. or….. RESTRICT / DO NOT RELEASE ANY INFORMATION

Name: _____Phone: _____Relationship: _____
LIST FIRST & LAST NAME

Please initial each section below to indicate you have read the information

_____ ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do hereby authorize payment of all insurance benefits, basic and major medical for these services, to be made directly to Advanced Dermatology. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees.

_____ STATEMENT TO PERMIT OF MEDICARE BENEFITS TO PROVIDER PHYSICIANS AND PATIENT

I request that payment of authorized Medicare or other applicable private insurance benefits be paid directly to Advanced Dermatology for services provided under their care. I also authorize Advanced Dermatology to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

_____ CONSENT FOR MEDICAL SERVICES

I authorize Advanced Dermatology to render treatment to me/my Dependents for dermatological care/medical procedures as may be deemed necessary.

_____ DIGITAL PHOTOGRAPHY

I authorize the physicians/staff of Advanced Dermatology to take digital photographs that relate to my care. Advanced Dermatology will only disclose information relevant to current treatment and is authorized to use photographs for educational or publication purposes provided my identity is protected. I may change this authorization at any time.

_____ RESPONSBILITY FOR PERSONAL PROPERTY

I understand that Advanced Dermatology does not assume RESPONSBIILITY FOR PERSONAL PROPERTY.

_____ REFERRALS/AUTHORIZATIONS

I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. **Payment in full is required at the time of service.**

_____ PRIVACY POLICY NOTICE

A copy of Advanced Dermatology's Notice of Privacy Policies may be requested detailing how my information may be used and disclosed as permitted under federal and state law.

_____ SURESCRIPTS MEDICATION/PRESCRIPTION NETWORK DATABASE

I authorize Advanced Dermatology & Skin Care Centre to access my Surescripts Medication History for providing clinical care in order to make more informed clinical decisions regarding my healthcare. A copy of Surescripts Network Policy is available upon request.

_____ MISSED APPOINTMENTS

Our office requires a **24 hour notice for cancellations**. Failure to do so may result in a **$30 fee for medical** appointments and **$50 fee for cosmetic** appointments.

May we leave personal information on your answering machine at home? ☐ Yes ☐ No

special Instructions_____

_____	_____	_____
DATE	SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE	SIGNATURE OF SPOUSE/RELATIONSHIP
_____	_____	_____
DATE	WITNESS	

ADVANCED DERMATOLOGY & SKIN CARE CENTRE MEDICAL HISTORY Today's Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____

Are you allergic to Medications: YES NO If "YES": list below

1. _____ 2. _____ 3. _____

Have you ever had dental anesthesia (Novocain)? YES NO Any bad reactions: YES NO If "YES," what? _____

Please list medications you are currently taking. (Including prescription, over the counter, and vitamins)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you have now, or ever had any of the following diseases or conditions: (Please check YES or NO)

MEDICAL HISTORY - PATIENT	YES	NO
Prescribed Blood thinners		
Bronchitis		
Emphysema		
Asthma		
Chronic cough		
High blood pressure		
Heart attack		
Irregular heart beat		
Blood clots		
Pacemaker		
Defibrillator		
Diabetes		
Thyroid Disease		
Kidney disease / Dialysis		
Bladder problems		
Hepatitis / infectious disease		
Arthritis / Joint deformity		
Artificial joint		
Convulsions / Seizures / Epilepsy		
Lupus or Autoimmune disorder		
Dementia		
Skin Cancer		
Specific Skin Disease		
Any diseases or conditions not listed?		

FAMILY HISTORY	YES	NO	Person Diagnosed
Autoimmune disorder			
Diabetes			
Heart Disease			
High Blood Pressure			
Melanoma			
Skin cancer Non Melanoma			
Psoriasis			
Any other skin disease			

SOCIAL HISTORY - PATIENT	YES	NO
Do you use tobacco?		
If yes, How much:		
If quit, then when:		
Do you drink alcohol?		
If yes, how often:		
Any IV / Illegal drug usage?		
Exposure to HIV (AIDS)?		
Sexually Transmitted Disease		
Women: Are you pregnant or breast feeding?		
-- If pregnant, enter due date:		

SKIN HISTORY	YES	NO
Any surgery in the past 6 months?		
Do you have problems healing?		
Do you develop keloids (thick scars)?		
Do you bleed easily?		
Ever had a rash in reaction to :		
Medication		
Food		
Environment		
Bandages		
Topical Neosporin		
Other		

TODAY'S/RECENT ISSUES - REVIEW OF SYSTEMS	YES	NO
Allergies/Immunologic (e.g., seasonal allergies, itchy eyes, runny nose)		
Cardiovascular (e.g., chest pain, palpitations)		
Constitutional/Symptoms (e.g., fever, nausea)		
Endocrine (e.g., low energy, cold intolerance)		
Ears, nose, throat, mouth (e.g., swallowing problems, cold sores)		
Urinary (e.g., blood in urine, pain with urination)		
Bowel (e.g., diarrhea, unplanned weight loss)		
Blood/Lymphatic (e.g., enlarged nodes or glands)		
Muscle/ Joint (e.g., muscle aches, arthritis)		
Psychiatric (e.g., depression, anxiety)		
Respiratory (e.g., difficulty breathing, wheezing)		
Skin Condition (e.g., rash, non-healing sore)		
Receiving Hospice Care		

Form Completed by (circle one):
Patient Family member/Guardian Medical Assistant

Signature: _____ Date: _____