

Medical Intake Form



PATIENT INFORMATION			
LAST NAME	FIRST NAME	M.I.	DATE / /
STREET ADDRESS		APT #	HOME PHONE ()
CITY	STATE	ZIP	MOBILE PHONE ()
DRIVERS LICENSE NUMBER (Optional)		LAST 4 DIGITS OF S.S. #	
D.O.B. / /	AGE	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	EMAIL
MARITAL STATUS <input type="radio"/> MARRIED <input type="radio"/> SINGLE <input type="radio"/> DIVORCED <input type="radio"/> WIDOWED	PREFERRED LANGUAGE (IF OTHER THAN ENGLISH)		
MINOR/UNDER 18 YEARS OLD <input type="radio"/> YES <input type="radio"/> NO	GUARDIAN NAME		GUARDIAN PHONE ()
EMPLOYER		OCCUPATION	
EMPLOYER ADDRESS	CITY	STATE	ZIP
			EMPLOYER PHONE ()
EMERGENCY CONTACT		RELATIONSHIP TO PATIENT	PHONE ()
PRIMARY CARE PHYSICIAN			PHONE ()
HOW DID YOU HEAR ABOUT US?			
<input type="radio"/> OUR WEBSITE (PRECISIONSKININSTITUTE.COM)		<input type="radio"/> INSURANCE WEBSITE OR LIST	<input type="radio"/> MAGAZINE
<input type="radio"/> ANOTHER PATIENT		<input type="radio"/> REFERED BY DOCTOR	<input type="radio"/> FACEBOOK
<input type="radio"/> OTHER			
ALTERNATE ADDRESS _____			
PERSON RESPONSIBLE FOR PAYMENT IF PATIENT UNDER 18 YEARS OF AGE			
LAST NAME OF PERSON RESPONSIBLE FOR BILL	FIRST NAME	M.I.	HOME PHONE ()
STREET ADDRESS		APT #	MOBILE PHONE ()
CITY	STATE	ZIP	RELATIONSHIP TO PATIENT
INSURANCE INFORMATION			
PRIMARY INSURANCE	POLICY #	GROUP #	
PRIMARY INSURANCE POLICY HOLDER	RELATIONSHIP TO PATIENT		D.O.B. / /
SECONDARY INSURANCE	POLICY #	GROUP #	
SECONDARY INSURANCE POLICY HOLDER	RELATIONSHIP TO PATIENT		D.O.B. / /
CONSENTS			

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payments of medical benefits to Precision Skin Institute _____.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Payment is required for all services at the time they are rendered (this includes co-payments, deductibles, co-insurance, deposits and payments for cosmetic services). I have had a chance to read over the Financial Responsibility Form. If your account remains unpaid past 60 days a \$20.00 late fee will be added to all subsequent billing statements. Any accounts 90 days or more overdue will be referred to a collection agency and incur a 35% interest charge.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

I have had a chance to read over the HIPAA/Privacy Policy Form.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Please initial if we are non-par with insurance plan of if patient has no insurance coverage _____

Medical History Form



PATIENT INFORMATION			
LAST NAME	FIRST NAME	M.I.	DATE / /

PAST MEDICAL HISTORY				
<i>PLEASE CHECK ALL THAT APPLY</i>				
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> COLON CANCER	<input type="checkbox"/> RENAL DISEASE	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> PROSTATE CANCER
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> COPD	<input type="checkbox"/> GERD (reflux)	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> RADIATION TREATMENT
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CORONARY ARTERY DISEASE	<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> LEUKEMIA	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> ARTRIAL FIBRILLATION	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> LUNG CANCER	<input type="checkbox"/> STROKE
<input type="checkbox"/> BREAST CANCER	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> LYMPHOMA	<input type="checkbox"/> HYPOYTHYROID/HYPERTHYROID
<input type="checkbox"/> OTHER _____				

PAST SURGICAL HISTORY INCLUDING SKIN SURGERY (description/date)

SKIN DISEASE HISTORY				
<i>PLEASE CHECK ALL THAT APPLY</i>				
<input type="checkbox"/> ACNE	<input type="checkbox"/> BASAL CELL CARCINOMA	<input type="checkbox"/> ECZEMA	<input type="checkbox"/> MELANOMA	<input type="checkbox"/> PSORIASIS
<input type="checkbox"/> ACTINIC KERATOSES	<input type="checkbox"/> BLISTERING SUNBURNS	<input type="checkbox"/> FLAKING / ITCHY SCALP	<input type="checkbox"/> POISON IVY	<input type="checkbox"/> SQUAMOUS CELL CARCINOMA
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DRY SKIN	<input type="checkbox"/> HAY FEVER / ALLERGIES	<input type="checkbox"/> PRECANCEROUS MOLES	
<input type="checkbox"/> OTHER _____				

SUN DAMAGE AND SUNSCREEN INFORMATION			
DO YOU WEAR SUNSCREEN?	TAN IN A TANNING SALON?	DO YOU SPEND LONG HOURS IN THE SUN?	
<input type="checkbox"/> YES, (SPF _____) <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	

MEDICATIONS		
MEDICATIONS		
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS

SOCIAL HISTORY			
<i>PLEASE CHECK ALL THAT APPLY AND PROVIDE APPLICABLE INFORMATION</i>			
<input type="checkbox"/> CIGARETTE SMOKING <input type="checkbox"/> CURRENTLY DAILY SMOKER <input type="checkbox"/> SOME DAY SMOKER <input type="checkbox"/> NEVER SMOKED <input type="checkbox"/> FORMER SMOKER	OPTIONAL <input type="checkbox"/> NOT SEXUALLY ACTIVE <input type="checkbox"/> SEXUALLY ACTIVE <input type="checkbox"/> 1 PARTNER <input type="checkbox"/> MORE THAN 1 PARTNER <input type="checkbox"/> SAME SEX PARTNER	<input type="checkbox"/> DRUG USE <input type="checkbox"/> IV DRUG USE	<input type="checkbox"/> ALCOHOL USE <input type="checkbox"/> NONE <input type="checkbox"/> LESS THAN 1 DRINK <input type="checkbox"/> 1-2 DRINKS DAILY <input type="checkbox"/> 3 OR MORE DRINKS DAILY

FAMILY HISTORY OF SKIN DISORDERS AND/OR SKIN CANCER (1st degree relatives only)

PHARMACY INFORMATION		
PHARMACY NAME	LOCATION	PHONE ()

ALERTS			
<i>PLEASE CHECK ALL THAT APPLY AND PROVIDE APPLICABLE INFORMATION</i>			
ALLERGY TO <input type="checkbox"/> ADHESIVE (BANDAID) <input type="checkbox"/> LIDOCAINE (NUMBING AGENT) <input type="checkbox"/> TOPICAL ANTIBIOTICS	CURRENT CONDITIONS <input type="checkbox"/> ARTIFICIAL HEART VALVE/JOINT <input type="checkbox"/> DEFIBRILLATOR <input type="checkbox"/> PACEMAKER	<input type="checkbox"/> HISTORY OF MRSA <input type="checkbox"/> PREGNANT <input type="checkbox"/> NURSING	<input type="checkbox"/> REQUIRE ANTIBIOTICS PRIOR TO SURGERY <input type="checkbox"/> RAPID HEARTBEAT WITH EPINEPHRINE

COSMETIC HISTORY	
HAVE YOU EVER HAD A COSMETIC PROCEDURE?	
<input type="checkbox"/> YES, (ANY SIDE-EFFECTS? _____)	
<input type="checkbox"/> NO	
ARE YOU INTERESTED IN A COSMETIC PROCEDURE?	
<input type="checkbox"/> YES, (PLEASE SPECIFY _____)	
<input type="checkbox"/> NO	

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

**CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO**

I hereby give consent and permission to Precision Skin Institute, LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by Precision Skin Institute, LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that Precision Skin Institute, LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

Precision Skin Institute, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold Precision Skin Institute, LLC, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold Precision Skin Institute, LLC responsible for instances of these violations.

Signature: _____ Date: _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have been either given a copy of Notice of Privacy Practices if I requested one. I understand that the practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy. The Notice of Privacy Practices as well as Patients' Bill of Rights are also posted in the waiting area and can also be found on our website at <https://precisionskininstitute.com/privacy-policy/>

FINANCIAL POLICY

Due to the many changes in insurance policies it is no longer an easy task to interpret each individual policy, therefore we urge you, the patient to please make sure you understand your individual policy and how it applies to your payment responsibility. Please remember that your insurance policy is between you and your insurance company. If you require a referral to see a specialist it is your responsibility as the patient to obtain this referral before your office visit. Failure to do so will result in your appointment being re-scheduled. If you have a co-payment or out-of-pocket expenses, deductible, co-insurance etc. it must be paid at the time of service.

CANCELLATION AND NO-SHOW POLICY

Our office and providers want to ensure that all of our patients receive the best possible care. In order to do so, we try to ensure that all of our patients are seen in a timely fashion. When a patient does not cancel or show up for his/her appointment, the ability of others to be seen in a timely fashion is affected as this appointment goes un-used. Our policy is as follows:

24-hour notice must be given for General Dermatology appointments and 48-hour notice must be given for any cosmetic/surgical or appointments with our estheticians.

****If you have 3 or more "No-Show/Missed" appointments within a one-year time, a dismissal from the practice will be considered. You will be notified by letter if the dismissal was approved.*****

Failure to provide the proper notice or failure to show up for your scheduled appointment will result in the loss of your deposit or being charged a fee as below:

\$25.00 Regular Office Visit

\$50.00 New Patient Appointment (A credit card number will be requested at the time of making an appointment, the credit card on file will only be processed if patient No-Show)

\$75.00 Surgical appointment

\$100.00 Cosmetic Procedure/Laser appointment and Esthetician appointment

\$150.00 Appointment scheduled for 40 minutes or longer

DEPOSIT POLICY

A deposit is required for any cosmetic procedure and/or Esthetician appointment. If you **DO NOT** cancel within the 24 to 48 hours' notice you will lose your **deposit** and any other future **appointments** will require another **deposit** to secure your **appointment**.

Patient Name (print clearly)

Patient Signature

Date