Dermatology & MOHS Surgery
New Patient Paperwork

Patient Information:
Patient Name:_____
Parent's Name (if minor): _____
Date of Birth: _____/_____/_____ Social Security Number:_____-_____-_____
Mailing Address:_____
Street
_____
City State Zip

Home Phone:(_____) _____-_____
Cell Phone: (_____) _____-_____
Alt Phone: (_____) _____-_____
Work: (_____) _____ -_____

Email Address: _____

Primary Care Physician: _____
Phone Number: (_____) _____-_____

Pharmacy Name: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone Number:_____

Marital Status: ◡ Single ◡ Married ◡ Divorce ◡ Widow ◡ Other

Notify In Case of Emergency:
Name:_____
Relationship:_____ Home Number: (_____) _____-_____
Cell Number: (_____) _____-_____

Insurance Information:
If you are a **SELF PAY** patient, payment is due at the time of service. Please give your payment to the receptionist, along with your driver's license or state identification card so we can copy this information in your file.
If you are **NOT a self pay** patient, please give the receptionist your driver's license or state identification card and your insurance card(s) so we can copy this information in your file.

Please fill out if you are NOT the policyholder of your insurance
Policy Holder Information
Insurance Company Name:_____
Policy #:_____ Group #:_____
Address:_____
City:_____ State:_____ Zip:_____
Patient Relation to Insured: ◡ Self ◡ Spouse ◡ Child ◡ Other: _____
Policy Holder Name:_____
Policy Holder Date of Birth: _____/_____/_____ SSN: _____-_____-_____
Address of Policy Holder: _____
Street
_____
City State Zip

***** Please fill out front and back of both pages *****

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Consent for Treatment: i voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatments. I understand it may be necessary to perform a procedure, examination, and/or treatments. I understand it may be necessary to perform a procedure during my visit(s) with this office to necessitate a diagnosis and/or treatment, the necessity and any possible complications (to include, but not limited to: scarring, bleeding and/or infection). I understand an outside laboratory (Global Pathology/Aurora Diagnostics/Carepath/Quest Diagnostics) will be utilized for skin biopsy specimens obtained, and that is it my responsibility to follow up on tests which are performed or ordered by this office, and it is my financial responsibility for any costs that may occur with this pathologist. I understand Dermatology & MOHS surgery is not responsible for any charged from the pathology centers or Quest Diagnostics.

Physician Assistant(s)/Advanced Nurse Practitioner(s): This office employs Board Certified Physician Assistants, and/or Board Certified Advanced Nurse Practitioners that are trained in Dermatology by Dr.Johnny Gurgen, DO. During your visit, you will encompass evaluation/treatment by our Physician Assistant(s) and/or Advanced Nurse Practitioner(s). Our Physician Assistant(s) and Advanced Nurse Practitioner(s) work closely with our physician, and is supervised by our physician in all aspects of your care.

Financial Policy: We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate in discussing them with us. **Your insurance card(s) and driver's license or state identification card will be required at check in.** if is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current-accordingly, all self pay or insurance copayments, coinsurance and deductibles will be collected at the time of service payable by cash, check or credit/debit card. You are responsible for your office visit fees if you haven't met your deductible for the year. If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to have that referral faced to our office prior to your appointment. You are responsible for any non-covered charges not payable by your insurance policy.

I have read and understand the "Consent for treatment", "Physician Assistant(s)/Advanced Nurse Practitioner(s)", and "Financial Policy" of the practice, and i agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by practice.

Patient or Authorized Representative

Signature:_____

Relationship to patient:_____ **Date:**_____

Patient Name: _____

Medical History

Reason for Today's Visit:_____

Current Medication(s): **(if you are not taking any medications please check here ◡)**

Do you have any allergies to any medications? ◡ Yes ◡ No **Allergies to Latex?** ◡ Yes ◡ No

Allergies to Adhesives? ◡ Yes ◡ No **Allergies to Lidocaine or Epinephrine?** ◡ Yes ◡ No

Please list any medications or other allergies that you might have: _____
_____

Please list any past surgical history: _____
_____

Have you ever been told you have any of the following? **(Please circle all that apply)**

Asthma	COPD	Emphysema	Heart Problems	High Blood Pressure
High Cholesterol	Hepatitis	Psoriasis	Eczema	Skin Cancer: BCC SCC
HIV/AIDS	Lupus	Communicable Diseases		Thyroidism
Gastro Disease	Pacemaker/Defibrillator			History of Melanoma
Anemia	Liver Disease			Other Medical Problems

Please list any other medical history that is not listed above:_____
_____

Do you have a history of lymphoma or leukemia? Yes No

Have you ever had an organ transplant, radiation/chemotherapy treatments? Yes No

Are you on any immunosuppressants such as Humira, Enbrel, or Methotrexate? Yes No
If you answered yes to any of those questions, please explain:_____
_____

Do you have a family history of skin cancer or Melanoma? Yes No

Do you Smoke? Now _____ Never _____ Former _____

- How many packs a day?_____

Do you drink alcohol? ◡ No ◡ Moderate ◡ Heavy ◡ Social

Have you had the flu vaccine in the past year?	Yes _____	No _____
Have you ever had the pneumonia vaccine?	Yes _____	No _____
Do you have a history of psoriasis?	Yes _____	No _____
Do you have regular TB Screenings?	Yes _____	No _____

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HIPAA Notice of Privacy Practices Acknowledgement and Authorization

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 received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices at any time. A revised notice of privacy practices) may be obtained by forwarding a written request to Dermatology and MOHS surgery at 1340 Citizens Boulevard, Leesburg Florida 34748.

Please answer the following:

- May we call your home or other alternative location and leave a message in reference to any items that assist the [practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to your clinical care, including laboratory results among others?
  _____ Yes / _____ No (if yes, what is the alternate number(s) to be called:_____
- May we phone you at work and leave a message to call our office back?
  _____ Yes / _____ No
- May we mail to your home or alternative location regarding appointment reminders/patient statements?
  _____ Yes / _____ No
- Do we have your permission to talk to family members or other individuals?
  _____ Yes / _____ No
  If yes, please provide the names, phone number, and relationship to you:
  Name:_____ Phone Number:_____
  Relationship to Patient:_____

  Name:_____ Phone Number:_____
  Relationship to Patient:_____

By signing this form, i hereby give my consent for Dermatology and MOHS Surgery to use and disclose **protected health information (PHI)** about me to carry out **treatment, payment, and healthcare operations.** I acknowledge that i have received or have been given the opportunity to receive a copy of the Dermatology and MOHS SUrgery Notice of Privacy Practices and have also been given the opportunity to ask questions. A copy of this consent will be included in my chart for future references.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If i do not sign this consent, or later revoke it, Dermatology and MOHS surgery may decline to provide treatment to me.

PATIENT NAME (Print): _____

SIGNATURE: _____
DATE:_____/_____/_____