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: _____

Referring Physician: _____

Phone Number: (_____) _____-_____

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:

Company: :_____ Policy#:_____

Group #:_____

Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ D.O.B: _____ SSN: _____

Policy Holder Address: _____

*** SELF PAY - PAYMENT DUE AT TIME OF SERVICE ***

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

Dermatology & MOHS Surgery
Consent for Treatment & Financial Policy

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 it is 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:**_____

Dermatology and MOHS Surgery - Medical History Form

Patient Name: _____ Date: _____
Date of Birth: _____ Height: _____ Weight: _____
Reason for today's visit? _____

Were you referred to our office? ❑ Yes ❑ No : If yes, by who? _____
Do you have any allergies to medications, lidocaine, or epinephrine? ❑ Yes ❑ No
Do you have any allergies to latex or adhesives? ❑ Yes ❑ No
If answered "yes" to any questions listed above, please list: _____

Do you currently take any medications? ❑ Yes ❑ No - If yes, please list below:

Current Medication and Strength:	Dosing:

Have you had any surgeries? ❑ Yes ❑ No : If yes, please list: _____
_____

Do you have any of the conditions listed below:

Pacemaker/Defibrillator	Asthma	Lupus	Thyroid Issues
High Cholesterol	HIV/AIDS	Liver Disease	Communicable Diseases
High Blood Pressure	Hepatitis	Emphysema	History of Basal Cell Carcinoma
Gastro Disease	Anemia	Psoriasis	History of Squamous Cell Carcinoma
Heart Problems	COPD	Eczema	History of Malignant Melanoma

Please list any other personal medical conditions: _____
_____
Any personal history of lymphoma? ❑ Yes ❑ No
Have you had an organ transplant, radiation, or chemotherapy? ❑ Yes ❑ No
Are you on any immunosuppressants? ❑ Yes ❑ No
Is there any family history of malignant melanoma? ❑ Yes ❑ No

- If Yes, what family member: _____

Have you had a flu vaccine? ❑ Yes ❑ No
For 65 & older, have you had a pneumonia vaccine? ❑ Yes ❑ No
Do you get regular TB screenings? ❑ Yes ❑ No
Do you smoke? ❑ current smoker ❑ former smoker. Quit in _____ ❑ never smoker
Do you drink alcohol? ❑ No ❑ Moderate ❑ Heavy ❑ Social

Dermatology & MOHS Surgery

HIPPA 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:_____/_____/_____