**Integrated Dermatology of East Boca**
**NEW PATIENT REGISTRATION**

**NAME: _____ Date of Birth: ___/____/____Social Security#:_____**
**MM DD YY**

**ADDRESS: _____ CIY: _____ STATE: _____ ZIP: _____**

**GENDER: _____ Home Phone #:_____ Cell #: _____ Work #: _____**

**OCCUPATION: _____EMPLOYER: _____**

**EMERGENCY CONTACT: _____ RELATION: _____ PHONE #: _____**

**PHARMACY: _____ PHONE #: _____**

**NORTHERN ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____**

**EMAIL: _____ MARITAL STATUS: _____**
**RACE: _____ETHNICITY: _____**
**WHOM MAY WE THANK FOR YOUR REFERRAL: _____**
**May we leave a message on voice mail/answering machine? Yes No Initial:_____**
**May we discuss your healthcare with a family member? Yes No Initial:_____**
**With whom? _____**

**ALL PATIENTS PLEASE COMPLETE & SIGN BELOW**

**INSURANCE COMPANY: _____ ID #: _____**
**MEDICARE: _____ MEDICARE ID #: _____**

I authorize any holder of medical information to release any information that is required by my insurance company. As the responsible party, I agree that all charges incurred by me or my dependents for services rendered by the Dr. (except those paid directly by Medicare) are my financial responsibility. All court fees, attorney fees or other fees necessary to collect this account are payable by me. In the event of litigation arising from any medical services received at any time, I agree to binding arbitration and waive any other rights.

**SIGNATURE: _____ DATE: _____**

**MEDICARE PATIENTS ONLY, PLEASE READ & SIGN BELOW**

We are participating physicians and will file your claim for you. Today you will be responsible for "your part" which is 20% (unless you have an approved supplemental policy) plus your unmet deductible for the current year. I request that payment of authorized MEDICARE benefits be made on my behalf the Dr. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I have not pledged or assigned my benefits to any Health Maintenance Organization (H.M.O.)

**SIGNATURE: _____ DATE: _____**

**MEDICARE PATIENTS WITH SUPPLEMENTAL COVERAGE, READ & SIGN BELOW**

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me.

**SIGNATURE: _____ DATE: _____**

SUPPLEMENTAL INSUANCE COMPANY NAME: _____

SUPPLEMENTAL POLICY NUMBER**:** _____

**ALL PATIENTS PLEASE READ & SIGN. I UNDERSTAND THAT ALL SPECIMENS (BIOPSIES & CULTURES) WILL BE SENT TO & BILLED BY AN INDEPENDENT LAB.**

**SIGNATURE: _____ DATE: _____**

**Integrated Dermatology of East Boca**
**DERMATOLOGY MEDICAL HISTORY FORM**

Patient Name: _____ Date: _____
Reason for today's visit: _____
Name of Primary Care Physician: _____
Are you allergic to any medications? Yes No If yes, please list below:
1. _____ 2. _____3._____
Have you had dental anesthesia (Novocain)? Yes No Any bad reaction? Yes No
List all medications you are taking (RX, over-the-counter, vitamins, herbals):
(Or attach a copy of your medication list.)

| | | |
|---|---|---|
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**PAST MEDICAL HISTORY: (check any that apply to you)**

| | | | |
|---|---|---|---|
| __ Diabetes | __ Psoriasis | __ Cataracts | __ High Blood Pressure |
| __ Dermatitis | __ Arthritis | __ Eczema | __ Liver Disease |
| __ Thyroid Disease | __ Hives | __ Bleeding Disorder | __ Tuberculosis |
| __ Cancer (type) _____ | | __ Skin Cancer | __ Asthma |
| __ Atypical Moles | __ Bowel Disease | __ Stomach Ulcers | __ Hayfever |
| __ Stroke | __Heart Attack | __ Seizures | __ Kidney Disease |
| __Blood Clot | __ Allergies (other than to medicines) | | __ Hepatitis |
| __ Are you pregnant or planning a pregnancy? | | | __ HIV |

__ Do you have any ***changing*** or ***growing*** spots?
**HABITS:** Alcohol _____ Tobacco _____ Other Drugs _____

**DO YOU HAVE AN ADVANCE CARE PLAN(LIVING WILL/SURROGATE)?YES or NO** (Please Circle)
**IF YES, WHATS IS THE FULL NAME?: _____**

**FAMILY HISTORY: (check any disease in your family & list relative affected)**
____ Asthma, allergies or hayfever _____
____ Psoriasis _____
____ Skin Cancer _____

**Please read the following questions & circle how you feel:**
1. When looking at my face, I believe I look **younger than the same as older than my age**
2. When looking at my face, I am **not concerned somewhat concerned very concerned** about the appearance of my wrinkles.
3. When looking at my face, my wrinkles make me look **tired sad angry,** but I do not feel that way inside

**PLEASE READ CAREFULLY:**
Skin cancer can occur in any location, even hidden sites. Some kinds of skin cancer can occur in any age patient. There are several types of skin cancer, some of which are dangerous or even deadly if not detected early. Some people with serious skin cancer are not even aware of the cancerous existence. Dr. Redd would like to offer EVERY patient the option of having a total body cancer screening at your appointment. In many cases, this is done at no or little additional charge, but does require disrobing. Would you like to disrobe for a cancer screen? **YES** **NO**

**Integrated Dermatology of East Boca**
**1050 NW 15th Street Suite 201A**
**Boca Raton, FL 33486**
**561-368-4545**

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## Federal Regulations regarding your PROTECTED HEALTH INFORMATION

With my consent, Integrated Dermatology of East Boca may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Integrated Dermatology of East Boca's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent Integrated Dermatology of East Boca may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including results among others.

With my consent, Integrated Dermatology of East Boca may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as reminder cards and patient statements.

By signing this form, I am consenting to Integrated Dermatology of East Boca's use and disclosure of my PHI to carry out TPO.

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 no sign his consent Integrated Dermatology of East Boca may decline to provide treatment to me.

_____ I have received a copy of Integrated Dermatology of East Boca's Notice of Privacy Practices.

_____ I have been offered a copy of Integrated Dermatology of East Boca's Notice of Privacy Practices but do not want a copy.

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_____ _____

**Signature of Patient or Legal Guardian** **Date**

_____ _____

**Patient's Name PRINTED** **Date of Birth**