DERMATOLOGY
ASSOCIATES OF TAMPA BAY

Name: _____ **Date**: _____

Street Address: _____ City / State: _____
Zip Code: _____ **Date of Birth**: _____ **Gender**: FEMALE MALE

Phone Number (CELL): _____ **Phone Number** (HOME): _____

Preferred phone: __ Cell ___ Home **Marital Status**: Married Single Divorced Widowed

PERMISSION TO LEAVE A DETAILED MESSAGE: **YES OR NO**

Email Address: _____

Emergency Contact: NAME_____PHONE#_____

Language: ____ENGLISH____SPANISH____OTHER **Race**: ___WHITE___ AFRICAN AMERICAN___ ASIAN __OTHER___DECLINED

Ethnic Group: ___ HISPANIC OR LATINO ___ NON-HISPANIC OR LATINO ___ DECLINED

Primary Care Physician: _____ Phone#_____

Guarantor if applicable: _____ DOB: _____ /_____/_____

Preferred Pharmacy

Name: _____ Phone Number: _____

City or Zip Code: _____ **PERMISSION TO ACCESS OUR PHARMACY MEDICATION RECORDS**? **YES OR NO**

The Following insurance plans are accepted at this office.
Present your insurance card along with your driver's license so we may make a copy for your file.

Medicare_____ Blue Cross/Blue Shield Traditional, PPO and PPC and Health Options _____ United Health Care _____
Aetna ____ Cigna_____ Humana ____ Avmed ____

Insured **Name** and **Date of birth** _____relationship to insured _____

Permission is hereby granted to John Millns, M.D., PA, dba Dermatology Associates of Tampa Bay to render such ***medical and/or surgical treatment*** only after it has been discussed and deemed necessary and to release any information via fax or other method including Payment, Treatment or Health Care Operations per HIPAA guidelines. I understand I am responsible for all services rendered, insurance co-payments, coinsurance and deductibles. If my account becomes overdue and I understand that my account may be turned over to a collection agency.

Signature: **Date:**

MEDICARE PATIENTS MUST SIGN THE TWO AUTHORIZATIONS BELOW.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Dermatology Associates of Tampa Bay. Regulations pertaining to Medicare assignments of benefits apply.

Signature as it appears on Medicare Card: **Date:**

I authorize Medigap (***secondary insurance***) benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap (secondary) carrier any information needed to determine these benefits payable for related services

Signature as it appears on Medigap (secondary) card: **Date:**

Your personal information will not be shared with a third party except as authorized by you or by law. With your permission, we will send you appointment reminders as well as keep you up-to-date on the latest medical trends, new products and information regarding the practice.

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PATIENT NOTICE OF PRIVACY PRACTICES AND COMMUNICATIONS

John L Millns, MD, PA dba Dermatology Associates of Tampa Bay will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire Private Policy Notices is posted in the waiting room as well as at www.dermassociatesoftb.com.

From time to time, we may need to contact you or discuss your medical information with your family or someone else of your choosing. The information shared will be the minimum necessary based on the professional opinion of the healthcare provider.

For lab results and other information communicated to you by phone, you will be contacted by one of our nurses.

1. With whom may we speak regarding your health (*e.g.*, spouse, child, parent, etc.)?

Name	Phone No.	Relationship

2. May we call you, and if necessary, leave a message on your answering machine or voice mail regarding:

	Call You		Leave a Message	
Purpose	**Yes**	**No**	**Yes**	**No**
Results				
Your health				
Upcoming appointment(s)				
Billing matters, including that a charge in excess of $50.00 will be posted to your card				
Information regarding the practice				

3. May we send you e-mail regarding: * Email Address: _____

Purpose	Yes	No
Latest medical trends, new products, and information regarding the practice		

* We do not send medical or otherwise confidential information to you via e-mail. We use a third-party tool (e.g., Constant Contact) to provide these e-mail updates to you. You may opt-out of receiving these updates at any time.

You may choose, from time to time, to e-mail us information using regular e-mail. While e-mail is convenient, it does pose several risks. Please see the "Important Notice About E-mail Communications" notice for details.

RECEIPT of NOTICE OF PRIVACY PRACTICES and NOTICE ABOUT E-MAIL COMMUNICATIONS:
My signature below indicates that I have received a copy of my physician's "Notice of Privacy Practices" and "Important Notice About E-mail Communications."

_____ _____ _____

Signature of Patient / Legally Authorized Representative Printed Name Date

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Next-of-Kin ☐ Legal Guardian ☐ Power of Attorney

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In our efforts to go green and keep the cost of healthcare down we have implemented the following financial policy to cover incidentals. Our policy is very similar to a hotel check-in procedure.

If we are providers for your insurance company, you will be asked to pay the co-pay, deductible, or co-insurance amounts as dictated by your insurance plan. These charges will be held in Modernizing Medicine's (our service provider) vault until your insurance has paid their portion and/or notified us of your financial responsibility. At that time, any remaining balance due to Dermatology Associates of Tampa Bay will be charged to your credit card.

If we are NOT providers for your insurance plan OR you do not wish to participate in our financial policy, you will be required to pay in full at the time of your visit.

We will file your medical claim to your insurance company. If after receiving your Explanation of Benefits (EOB) from the insurance company it reflects any over-payment on your part, any credits will then be refunded to you.

It is in your best interest to understand your insurance plan.
This credit card policy will be an advantage to you as you will no longer have to prepare and mail us checks. This policy benefits everybody by keeping the cost of healthcare down, and by allowing us to concentrate first and foremost on your medical needs.

We care about the security of your credit card information. We take a number of steps to protect your credit card information. Once entered into Modernizing Medicine (our service provider) the information is encrypted and only shows our staff the last four digits of the card. This information will be stored when the receptionist swipes your card at check out. The security of our system is monitored 24/7 by IT3 Technology Solutions. We also utilize the Barracuda Firewall.

Our credit card on account policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays, co-insurances, and deductible amounts will, of course, still be due at the time of your visit.

Please note; you will receive a courtesy call to advise any charges that will be posted in excess of $200.00. Insurance companies normally take 2-3 weeks to process claims.

If you have any questions, please do not hesitate to ask.

I authorize John L Millns, MD, PA dba Dermatology Associates of Tampa Bay to charge outstanding balances on my account to the credit card used today at check out. Please provide just the expiration date of the card you will be using.

Exp Date _____/_____

Patient Name _____ Date of Birth _____

Signature _____ Date _____

6001 Memorial Highway Tampa, FL 33615 Phone: 813-884-1626

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DATE:_____

PATIENT NAME:_____ **DOB:**_____

PAST MEDICAL HISTORY (Please check all that apply to you)

☐Anxiety
☐Arthritis
☐Asthma
☐Atrial Fibrillation (Irregular Heartbeat)
☐Bone Marrow Transplant
☐BPH (Enlarged prostate)
☐Breast Cancer
☐Colon Cancer
☐COPD
☐Coronary Artery Disease
☐Depression
☐Diabetes
☐End Stage Renal Disease
☐GERD (Acid Reflux)
☐Hearing Loss
☐Hepatitis
☐HIV/AIDS
☐Hypertension (High Blood Pressure)
☐Hypercholesterolemia (High cholesterol)
☐Hyperthyroidism
☐Hypothyroidism
☐Leukemia
☐Lung Cancer
☐Lymphoma
☐Prostate Cancer
☐Radiation Treatment
☐Seizures
☐Stroke
☐Other:
☐**NONE of the Above**

PAST SURGICAL HISTORY (Please check all that apply to you)

☐Appendix Removed
☐Bladder Removed
☐Breast Biopsy
☐Lumpectomy:
  ☐Right
  ☐Left
  ☐Both
☐Mastectomy:
  ☐Right
  ☐Left
  ☐Both
☐Colon Removed for:
  ☐Colon Cancer
  ☐Diverticulitis
  ☐IBD (Inflammatory Bowel Disease)
☐Colostomy
☐Gallbladder Removed
☐Coronary Artery Bypass
☐Pacemaker
☐Mechanical Valve Replacement
☐Biological Valve Replacement
☐Joint Replacement, Knee:
  ☐Right
  ☐Left
  ☐Both
☐Joint Replacement, Hip:
  ☐Right
☐Kidney Biopsy
☐Kidney Removed:
  ☐Right
  ☐Left
  ☐Both
☐Kidney Stone Removal
☐Kidney Transplant
☐Liver Transplant
☐Ovaries Removed:
  ☐Endometriosis
  ☐Ovarian Cyst
  ☐Tubal Ligation
☐Pancreas Removed
☐Prostate Removed: Prostate Cancer
☐Prostate: Biopsy
☐Prostate: TURP
☐Spleen Removed
☐Hysterectomy:
  ☐Fibroids
  ☐Uterine Cancer
  ☐Cervical Cancer
☐Skin Cancer Surgery:
  ☐Not sure of type
  ☐Squamous Cell Carcinoma
  ☐Basal Cell Carcinoma
  ☐Other Type:

☐Left
☐Both

☐**NONE of the above**

SKIN DISEASE HISTORY (please check all that apply to you)

☐Acne
☐Actinic Keratosis (Precancerous skin growths)
☐Asthma
☐Basal Cell Carcinoma
☐Blistering Sunburns
☐Dry Skin
☐Eczema
☐Flaking or Itchy Scalp
☐Hay Fever/Allergies
☐Melanoma
☐Poison Ivy
☐Precancerous Moles (usually called atypical nevi or dysplastic nevi)
☐Psoriasis
☐Squamous Cell Carcinoma
☐Squamous Cell Carcinoma in situ
☐Other Kind of Skin Cancer
☐Skin Cancer but not sure what kind
☐Other Skin Disease or Condition

☐**NONE of the above**

CURRENT MEDICATIONS

Please list all current prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary or nutritional supplements.)

***** If you brought a list of medications with you, we can use your list. *****

Name	**Dosage**	**How often**	**How do you take it?** (by mouth, patch, injection)

ALLERGIES (Please list all medication allergies)

Are you allergic or sensitive to:

Adhesive	Yes ☐	No ☐
Lidocaine	Yes ☐	No ☐
Epinephrine	Yes ☐	No ☐
Latex	Yes ☐	No ☐

Any other types of allergies?_____

SOCIAL HISTORY

Do you smoke? ☐Never ☐Former Smoker ☐Less than daily ☐Daily

FAMILY HISTORY

Has anyone in your family ever had? (Please check, if applicable**)**

Melanoma ☐Yes ☐No

If so, was it your biological ☐Mother, ☐Father, ☐Sister, ☐Brother, ☐Son, ☐Daughter, ☐Aunt, ☐Uncle, ☐Nephew, ☐Niece, ☐Grandmother, ☐Grandfather, ☐Grandson, ☐Granddaughter

Any other kind of skin cancer? ☐Yes ☐No **Pre-cancer?** ☐Yes ☐No

☐Asthma, ☐Hay Fever, ☐Eczema, ☐Psoriasis, ☐Diabetes, ☐Thyroid Disease, ☐Arthritis, ☐Lupus, ☐any other Skin Disease? **(Please check all that apply)**

For patients over 65 years of age:

Medical Proxy:
Person who makes medical decisions on your behalf, if you are not able to?

Name: _____ Phone number: _____

Do you have a living will? YES NO

Have you had your pneumococcal vaccination? YES NO

Thank you for filling out this form

****** NOTE ******

We remind patients about future appointments by phone, email, and text.
Please discuss other contact preferences with the office reception.