PALM BEACH DERMATOLOGY

□ Judith V. Redd, MD □ Adam S. Aldahan, MD □ Meylin Vega, PA-C

NEW PATIENT INFORMATION

Date_____

Patient Name: Last_____First_____Middle_____Date of Birth_____

□ Male □ Female □ Married □ Single □ Widowed □ Divorced

Primary Address_____City _____State_____Zip_____

Seasonal Address_____City _____State_____Zip_____

Home Phone_____Cell_____Work_____Alternate Number_____

Email Address_____

Preferred Method of Contact for appointment reminders: □ Cell □ Home □ Work

Referred by_____Physician_____ □ Yes □ No

If under 18 years of age, name of parent or guardian_____

Patient/parent/guardian's occupation_____

Employer Name_____Address_____Employer Phone_____

Emergency Contact person not residing with you_____Phone_____

Relationship to you: □ Friend □ Relative □ Other_____

LIFETIME AUTHORIZATION

For the Release of Medical Records

I authorize the release of any medical information required by my insurance carrier(s) needed for this or any related claim. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Health Care Financing Administration or its intermediaries or carriers any information needed for this insurance claim or any related medical claim

For the payment of benefits to the Physician/Provider

I, the undersigned, understand that Palm Beach Dermatology has agreed to accept Medicare and/or health insurance for payment of my bills by my signature below. I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance due after Medicare/Health insurance payments and will be paid by me to Palm Beach Dermatology. I understand that I will be billed for the remaining unpaid balance and I understand that I am financially responsible for any charges not covered by this authorization.

Patient Signature_____Date_____

METHOD OF PAYMENT

Payment is required at the time services are rendered. Palm Beach Dermatology is a participating provider with Medicare, Blue Cross Blue Shield of Florida, and many other PPO Insurance plans. Please check with our front desk staff to see if we participate with your health care insurance plan. Preferred Provider Plans (PPO) medical claims will be filed automatically by our office. Please present your insurance card(s) to our front desk staff for photocopy/scanning and benefit verification.

Will you be paying by: □ Cash □ Check □ Credit Card *Valid State ID or Driver's License is required if paying with Credit Card or Check*

The information requested on this form must be completed in its entirety and will remain confidential. Your selection of Palm Beach Dermatology for your care is greatly appreciated. If you have any questions or require assistance please do not hesitate to ask. We are happy to be of service to you.

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Patient Name_____Date_____

Primary (Default) Pharmacy Name_____Phone_____

Past Medical History

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation

☐ Bone Marrow Transplant ☐ Enlarged Prostate ☐ Breast Cancer ☐ Colon Cancer

☐ COPD ☐ Coronary Artery Disease ☐ Depression ☐ Diabetes

☐ End Stage Renal Disease ☐ GERD ☐ Hearing Loss ☐ Hepatitis

☐ Underactive Thyroid ☐ Leukemia ☐ Prostate Cancer ☐ Seizures

☐ Radiation Treatment ☐ Stroke ☐ Hypertension ☐ Other_____

Past Surgical History

☐ Appendectomy ☐ Bladder Removed ☐ Colostomy ☐ Gallbladder Removal

☐ Pancreas Removed ☐ Spleen Removed ☐ Hysterectomy ☐ Ovaries Removed

☐ Coronary Artery Bypass Surgery ☐ Tubal Ligation ☐ Testicle Removed ☐ Colon Removed

Breast: ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy ☐ Right ☐ Left ☐ Both

Heart: ☐ Valve Replacement ☐ Biological ☐ Mechanical ☐ Transplant ☐ Stent

Liver: ☐ Liver Removal ☐ Transplant ☐ Shunt

Knee Replacement: ☐ Right ☐ Left ☐ Both Hip Replacement: ☐ Right ☐ Left ☐Both

Kidney: ☐ Biopsy Cancer ☐ Tumor Rectum: APR ☐ Low Anterior Resection

Skin: ☐ Basal Cell Carcinoma ☐ Melanoma ☐ Skin Biopsy ☐ Squamous Cell Carcinoma

Other:_____

Skin Disease History

☐ Acne ☐ Actinic Keratosis (precancer) ☐ Asthma ☐ Basal Cell Carcinoma ☐ Blistering Sunburns

☐ Dry Skin ☐ Eczema ☐ Flaking/Itchy Scalp ☐ Hay fever ☐ Allergies ☐ Melanoma

☐ Poison Ivy ☐ Precancerous Moles ☐ Psoriasis ☐ Squamous Cell Carcinoma

☐ Other_____

Do you wear sunscreen ☐ Yes ☐ No SPF_____ Do you use tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No Which relative?_____

Medications_____

_____

Allergies_____

Smoking status ☐ Never smoked ☐ Former smoker ☐ Sometimes ☐ Everyday Number of packs per day _____

Alcohol use ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

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For Patients 65 and older: Have you received a pneumonia vaccination? □ Yes □ No

Have you received Flu Vaccine this year (January through March or October through December) □ Yes □ No

Do you have a health care proxy? □ Yes □ No

Designated health Care Proxy name_____Phone_____

Do you have a living will? □ Yes □ No

How many times in the past year have you had 5 or more alcoholic drinks in a day for men_____

How many times in the past year have you had 4 or more alcoholic drinks in a day for women_____

Review of systems

□ Problems with bleeding
□ Problems with healing
□ Problems with scarring (hypertrophic/keloid)
□ Rash
□ Immunosuppression
□Hay fever
□Chest pain
□ Fever or chills
□ Night sweats
□ Unintentional weight loss
□ Thyroid problems
□ Sore throat
□ Blurry vision
□ Abdominal pain
□ Bloody stool
□ Bloody urine
□ Joint aches
□ Muscle weakness
□ Neck stiffness
□ Headaches
□ Seizures

□ Cough
□ Shortness of breath
□ Wheezing
□ Anxiety
□ Depression
□ Changing moles
□ Allergy to adhesive
□ Allergy to lidocaine
□ Allergy to topical antibiotic ointments
□ Artificial heart valve
□ Artificial joints within past two years
□ Blood thinners
□ Defibrillator
□ MRSA
□ Pacemaker
□ Premedication prior to procedure
□ Rapid heartbeat with epinephrine
□ Pregnancy or planning pregnancy
□ West Africa: travel/contact
□ HIV AIDS
□ None

COVID-19 Screening

□ Fever above 100 degrees or chills
□ Upper respiratory symptoms (cough, shortness of breath, sore throat)
□ Gastrointestinal symptoms (abdominal pain, diarrhea)
□ New loss of taste or smell
□ Muscle pain
□ Household member, intimate partner or caregiver & has tested positive for COVID-19 in the past 14 days

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CONSENT AND ACKNOWLEDGMENT

I authorize Palm Beach Dermatology, Inc. personnel to perform dermatology (skin care services. This authorization includes, but is not limited to, performing medically necessary surgical procedures such as a skin biopsy, removal of pre-cancerous and cancerous skin lesion. I consent to the disposition by Palm Beach Dermatology, Inc. of any tissue parts which may be removed. I understand that there are always certain risks and consequences that are associated with the aforesaid procedures. These among others, are scarring, pigmentary changes to the skin, recurrence of skin cancer or other lesions/problems and possible damage to blood vessels, or parts next to them, such as nerves, infection or allergic reactions or other complications. I acknowledge that no guarantee or assurance has been made to me as to any of their results or risks and I assume such risk. I understand that the practice of medicine is not an exact science. I will ask if I want to have further explanation, discussion, or description of the risks involved in these procedures.

I consent to the disposition by Palm Beach Dermatology, Inc., of any tissue parts, which may be removed from named patient. I understand that this tissue will be sent for pathologic evaluation to a board certified dermatopathologist and that named patient will be financial responsible for all the charges related to this evaluation regardless of the reimbursement from insurance carrier. I also understand that I will not hold Palm Beach Dermatology, Inc. professionally or personally responsible for the pathologic interpretation of said tissue and that this tissue may be sent for additional tests or evaluation by me or my insurance company's expense.

FOR PATIENT'S UNDERGOING SKIN CANCER TREATMENT OR EVALUATION

I understand that if I have skin cancer, it is my responsibility to seek follow up care by Palm Beach Dermatology, Inc. personnel or other dermatology professional at a minimum of six months. Failure to seek follow up care is my responsibility and I do not hold Palm Beach Dermatology, Inc. personnel professionally or personally responsible for skin cancer follow up. It is also the patient's responsibility to contact the office immediately if there is a change in appearance or sensation of a previously treated or evaluated skin growth or new growth (such as but not limited to color, size, shape, pain, bleeding, etc.)

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature/Patient, Parent or Legal Guardian Date

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NOTICE OF PATIENT PRIVACY PRACTICES CONSENT

I, _____have been given the opportunity to read a copy of

(Print Patient Name)

Palm Beach Dermatology's NOTICE OF PATIENT PRIVACY PRACTICES.

Patient Signature_____Date_____

Parent or Legal Guardian Signature_____Date_____

May we leave appointment information on your answering machine? ☐ Yes ☐ No

Please be advised we are unable to leave any lab or pathology results on an answering machine.

Do you authorize our office to discuss your medical information with family members or other individuals?

☐ Yes ☐ No

If yes, please provide names and phone numbers below:

Name _____Relationship_____

Phone_____Alternate Phone_____

Name _____Relationship_____

Phone_____Alternate Phone_____