ROBERT J. SIRAGUSA, M.D.
Diplomate, American Board of Dermatology
CHARLES R. KOVALESKI, M.D.
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DERMATOLOGY ASSOCIATES
SKIN & CANCER CENTER

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BRET JOHNSON, M.D.
Diplomate ABFM, Specialty in Dermatology
NANCY WATSON, P.A.

PATIENT INFORMATION

Name ____
First MI Last Nickname

Date of Birth ______________________ Phone ______________________
Month Day Year

Social Security #________________ Cell ________________ Work ________________

Mailing Address ____

______________________________ Email ______________________
City State Zip

PRIMARY INSURANCE:

Carrier Name ______________________ Policy Holder Name: ______________________

Policy Holder DOB: ______________________ Relationship to patient: ______________________

SECONDARY INSURANCE:

Carrier Name ______________________ Policy Holder Name: ______________________

Policy Holder DOB: ______________________ Relationship to patient: ______________________

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

______________________________ ______________________
X Patient Signature / Legal Guardian's Signature Date

Patient Financial Responsibility

I understand and agree to pay for all charges incurred regardless of insurance coverage. I hereby authorize my insurance carrier to pay and assign all medical and/or surgical benefits to Dermatology Associates.

______________________________ ______________________
X Patient Signature / Legal Guardian's Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM.

I,______________________________, have received a copy of or was offered a copy of Dermatology Associates Notice of Privacy Practices.

______________________________ ______________________
X Signature of Patient Date

NAME:___________________________ **DATE OF BIRTH:**______________

Sex: Male or Female

Marital Status: ______________

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Yes or No (please circle one)

Preferred Language: (circle one)
English
Spanish
Other: ________________________

Name of Primary Care Doctor

____

Address: ____

Phone: ____

Is it ok to leave a detailed message on your answering machine? Yes or No (Please Circle One)

Is it ok to mail results or reminders to your home address? Yes or No (please circle one)

Emergency Contact Information /Consent to release health information to certain individuals.
Please list any person(s) and phone number(s) that we may contact regarding any treatment, payment, or any healthcare operation.

NAME: ________________ PHONE: ________________ RELATIONSHIP: ________________
NAME: ________________ PHONE: ________________ RELATIONSHIP: ________________
NAME: ________________ PHONE: ________________ RELATIONSHIP: ________________
NAME: ________________ PHONE: ________________ RELATIONSHIP: ________________

Pharmacy: Name: ________________________________
Address: ________________________________ Phone Number: ____________________

____

We send all biopsies to Ketchum, Wood & Burgert Pathology Associates in Tallahassee. If your insurance company requires that your biopsy be sent somewhere else, please indicate here: ___________________________ Otherwise, do we have your permission to send your biopsy to KWB Pathology?

Yes or No (please circle one)

Please list any medical or surgical history:

- ❑ Arthritis
- ❑ Diabetes
- ❑ Renal disease
- ❑ HIV/AIDS
- ❑ Hepatitis A, B, or C
- ❑ Hypertension
- ❑ Pacemaker
- ❑ Seizures
- ❑ Stroke
- ❑ Heart valve replacement
- ❑ Hip replacement - R / L
- ❑ Knee replacement - R / L
- ❑ Colectomy
- ❑ Mastectomy
- ❑ Mechanical Valve Replacement
- ❑ Heart Transplant
- ❑ Kidney Transplant
- ❑ Basal Cell Carcinoma
- ❑ Squamous Cell Carcinoma
- ❑ Melanoma

Other: ______________________________

Please List any Drug Allergies: ______________________________

Have you had the following vaccinations this year?

Flu vaccination? YES or NO (please circle one)
If previosuly received what date? ____________
Pneumonia vaccination? YES or NO
If previosuly received what date? ____________

Smoking history:
- ❑ Never smoked
- ❑ Quit/Former smoker
- ❑ Smokes less than daily
- ❑ Smokes daily

Medication list: Please include name, strength, dosage, and frequency of each medication:

Do we have permission to request your prescription list from the pharmacy? **YES** **NO** *Please Circle One*

Do you have a family history of melanoma? YES or NO

If so, which relative? ______________________________

If over 65 years of age:

Do you have a healthcare proxy? YES or NO

Whom: ______________________________

Relationship: ______________________________

Phone: ______________________________

Do you have a Living Will? YES or NO

Which statement best reflects your wishes on advanced care recommendations:

- ❑ Do Not Intubate
- ❑ Do Not Resuscitate
- ❑ Full Cardiopulmonary Resuscitation