



DERMATOLOGY ASSOCIATES
 — SKIN & CANCER CENTER —
 (850) 769SKIN (7546) • Fax (850) 785-2123
 1900 HARRISON AVE. • PANAMA CITY, FL 32405
 www.769skin.com

ROBERT J. SIRAGUSA, M.D.
 Diplomate, American Board of Dermatology

CHARLES R. KOVALESKI, M.D.
 Diplomate, American Board of Dermatology

CHARLES A. BYRON, PA-C, M.P.A.S.

BRET JOHNSON, M.D.
 Diplomate ABFM, Specialty in Dermatology

CHRISTOPHER WOLFE, DO
 Fellowship - trained Mohs surgeon

STEPHEN PLUMB, M.D.

KELLY WOOD, PA

MARY CARMON, A.P.R.N.

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 _____ Date
 Signature of Patient

SEX: Male or Female
Gender Identity: _____

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)

Name of Primary Care Doctor

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

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

Is it ok to mail results or reminders to your home address? Yes or No (Please Circle One)

Occupation: _____

City, State: _____ Place of Birth: _____

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: _____

Pharmacy: Name: _____

Location: _____

You may have a biopsy performed today during your visit. It is the patient's responsibility to supply the name of the laboratory that your insurance plan covers for these biopsies. Our in-house lab is contracted with most insurance plans, but if your insurance requires that your biopsy be sent elsewhere, please indicate this in the space provided: _____ Otherwise, all biopsies will be sent to Dermatology Associates Lab.

Patient Initial and Date: _____

Please list any medical or surgical history:

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

Other: _____

Please List any Drug Allergies: _____ NONE

Please circle NONE if no known drug allergies

Have you had the following vaccinations this year?

Flu vaccination? YES or NO (please circle one)
 If previously received what date? _____
 Pneumonia vaccination? YES or NO
 If previously 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 **YES NO** prescription list from the pharmacy? *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 Medical Power of Attorney? YES or NO

Whom: _____

Relationship: _____

Phone: _____

Do you have a Living Will? YES or NO

I am unable to respond to these questions

Which statement best reflects your wishes on advanced care recommendations:

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

