Curtis Dermatology, P.A.

10817 S. Jog Road, Suite #236 • Boynton Beach, Florida 33437 • (561) 777-7703 • (561) 777-7704

PATIENT INFORMATION

Date _____ **E-mail Address** _____

Patient Name _____ **Age** _____ **Date of Dob** _____
First Middle Last

☐ Married ☐ Widowed ☐ Male
SS# _____ ☐ Single ☐ Divorced ☐ Female

Local Address _____ **Home Phone** _____
Apt. No. City State Zip

Cell Phone _____
Permanent Address _____ **Work Phone** _____
Apt. No. City State Zip

Person to Pay Bill _____ **Relationship** _____

Address _____ **Work Phone** _____

Race _____ **Cell Phone** _____
Which do you consider yourself? _____ **Hispanic or Latino** _____ **Not Hispanic or Non-Latino**
Which language do you prefer to use to communicate? _____ **English** _____ **Spanish** _____ **Other**

Name of SPOUSE (or PARENT) _____ **SS#** _____

PATIENT Employer _____ **Occupation** _____ **Work Phone** _____
Address _____

SPOUSE / PARENT Employer _____ **Work Phone** _____
Address _____

To Notify in Case of Emergency _____ **Relationship** _____ **Phone** _____

Referred by _____

Primary Insurance _____ **Secondary Insurance** _____

Pharmacy _____ **Address / Cross Streets** _____ **Phone** _____

Consent to Release My Medical Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), I give my permission for Curtis Dermatology, P.A. to call the **designated number(s) and leave a detailed message** on voicemail, or in person, in reference to any items that assist the practice including but not limited to, appointment reminders, insurance items, account collection, queries concerning missed or cancelled appointments, test results, medical condition and/or my clinical care.

_____ _____ _____
Patient Signature **Printed Name** **Date**

_____ _____
Number(s) to call (Circle: Cell, Home, Work, Other)

I hereby give permission for the person(s) listed below to receive any of my lab results and/or to discuss my medical condition.

Name(s): _____ **Phone #** _____
Name(s): _____ **Phone #** _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

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NEW PATIENT HISTORY

Name (Printed): _____ Date of Birth: _____ Age: _____

Please Check the Boxes Below for Any Conditions You Have or Have Ever Had

Y	N		Y	N		Y	N	
❒	❒	Allergies / Hay Fever	❒	❒	Hip / Knee / Joint Surgery	❒	❒	Substance / Alcohol Abuse
❒	❒	Asthma	❒	❒	Organ Transplant	❒	❒	Serious Infection
❒	❒	COPD / TB	❒	❒	Kidney / Urinary Disease	❒	❒	Herpes / STD / Venereal Disease
❒	❒	A Fib	❒	❒	Anemia	❒	❒	HIV+
❒	❒	Heart Attack/Heart Disease	❒	❒	Bleeding Problems	❒	❒	Anxiety/Depression
❒	❒	Pacemaker / Defibrillator	❒	❒	Leukemia or Lymphoma	❒	❒	Psychiatric Problems
❒	❒	Heart Valve / Murmur	❒	❒	Large Change in Weight	❒	❒	Changing Mole/ Dysplastic Mole
❒	❒	High Blood Pressure	❒	❒	Cancer (not skin) _____	❒	❒	Hair Loss
❒	❒	Endocarditis	❒	❒	Abdominal Pain	❒	❒	Nail Fungus / Nail Disease
❒	❒	Bone Marrow Transplant	❒	❒	Gastrointestinal Disease	❒	❒	Psoriasis
❒	❒	BPH	❒	❒	Liver Disease / Hepatitis	❒	❒	Eczema
❒	❒	High Cholesterol	❒	❒	Stomach Ulcer / Heartburn	❒	❒	Recurrent Blisters (Mouth /Skin)
❒	❒	Diabetes	❒	❒	Recent Hospitalization / Surgery	❒	❒	Keloid Scars
❒	❒	Hormonal Problems	❒	❒	Headache (severe/recurrent)	❒	❒	Skin Cancer (BCC / SCC)
❒	❒	Thyroid Disease	❒	❒	Stroke / TIA	❒	❒	Skin Cancer (Melanoma)
❒	❒	Autoimmune Disease	❒	❒	Seizure/Neurological Disease	❒	❒	Family History of Skin Cancer
❒	❒	Lupus / Scleroderma	❒	❒	Multiple Sclerosis	❒	❒	Skin Disease Not Listed
❒	❒	Arthritis / Joint Pain	❒	❒	Cataracts / Glaucoma	❒	❒	Taken Accutane in Last Year

Do you have Advanced Directive/Living Will? ❒ Yes ❒ No Surrogate: `

Have you received a flu shot this year? ❒ Yes ❒ No Taking Hormones/Birth Control? ❒ Yes ❒ No

Pneumonia Vaccine (>65 years old)? ❒ Yes ❒ No Planning Pregnancy, Pregnant or Nursing? ❒ Yes ❒ No

Explain "Yes" to Medical Conditions and List any Other Medical Problems Not Listed Above: _____

_____

Any Family history of Diabetes, Heart Disease or Cancers (including skin)? (List first degree relatives only):

_____

Do You Take Antibiotics Before Dental Work or Surgical Procedures? ❒ Yes ❒ No Rx: _____

Do You Drink Alcohol? ❒ Yes ❒ No If Yes, ____ Drink(s) per Week ____ Occasionally

Do You Smoke? ❒ Yes ❒ No ❒ Past use If Yes, ____ Pack(s) per Day ____ Occasionally

Are You Allergic To: ❒ Adhesive ❒ Antibiotic Ointment ❒ Epinephrine ❒ Iodine ❒ Latex ❒ Lidocaine

Do You Have Any other ALLERGIES to MEDICATION? ❒ Yes ❒ No

Please list Medication Name and Reaction:

_____

_____

Please List All Prescription and Over-the-Counter Medications You Take: _____

_____

_____

_____

Do you wear sunscreen ❒ Yes ❒ No Any tanning bed use? ❒ Yes ❒ Past use ❒ Never

Who Referred You to Our Office? _____

Primary Physician: _____ Phone Number: _____

I declare that I have read the foregoing and the answers are true to the best of my knowledge. I also consent to be evaluated and treated by the healthcare provider.

Patient / Guardian Signature: _____ Date: _____

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RELEASE OF INFORMATION & MEDICAL TREATMENT

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize Curtis Dermatology, P.A. to release to my insurance carrier and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process the claim.

I request that the payment of authorized benefits be made on my behalf. I hereby assign the benefits payable for physician services to Curtis Dermatology, P.A. and authorize Curtis Dermatology, P.A. to submit my claim to my health insurance carrier (including Medicare) for payment of medical services rendered to me. This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned.

I also understand that any portion of the fee not paid by my insurance carrier/company (including deductibles) will become my personal obligation and will be paid promptly by me. I understand that I am responsible for obtaining referrals and authorizations from my insurance carrier. Failure to do so may result in my being billed for the unauthorized procedure. I also understand I will be responsible for any and all collection fees at $25 per month on a past due balance until the balance is paid in full. I understand that any procedure in addition to the office visit will incur additional charges, such as laboratory work; any lab work that will be sent out to an independent/outside laboratory will be billed to me directly by the Lab Company and not by Curtis Dermatology, P.A**.**

I understand that Curtis Dermatology enforces a No Show and Late Cancellation Policy in which I will be responsible for paying a $25 fee if an appointment is not cancelled within the allowed 24 hours.

I authorize my signature to be placed "on file" for the purpose of Medicare and insurance claim form submission.

I acknowledge full responsibility for payment of services rendered and agree to pay for them in full, at the time of service, unless other arrangements have been made in advance with this office.

I also give my permission to Curtis Dermatology, P.A. and to the physician furnishing the services for any treatment necessary. Under the penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

_____ _____

Patient / Guardian Signature Date

INSURANCE ASSIGNMENT AGREEMENT/PRIVACY NOTICE ACKNOWLEDGEMENT
PLEASE SIGN THE RELEASE BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____

Name of Insurance Company (ies)

_____, and assign directly to Curtis Dermatology, P.A. all insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize Curtis Dermatology, P.A. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Beneficiary/Patient Signature Relationship Date

MEDICARE Lifetime Authorization. Medicare patient certification. Patient certification authorization to release information and payment request.

I certify that the information given by me in applying for payment under Title XVII and /or Title XIX of the Social Security Act if correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance.

_____ _____ _____

Patient Signature Print Patient Name Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____ _____

Patient Signature Print Patient Name Date

_____

Parent or Authorized Representative (if applicable)