PATIENT INFORMATION

NAME: _____ DATE: _____
(Last) (First) (MI)

BIRTHDATE: _____ SOCIAL SECURITY #: _____

Male: _____ Female: _____ MARITAL STATUS: S ____M ____D ____W ____

ADDRESS: _____APT: _____ CITY/ STATE: _____ ZIPCODE: _____

HOME #: _____ WORK#: _____ CELL#: _____

E-MAIL ADDRESS: _____

RACE: WHITE ____ BLACK/AFRICAN AMERICAN ____ ASIAN ____
HAWAIIAN/PAC. ISLANDER _____ MIXED ____

ETHNICITY: NON-HISPANIC ____ HISPANIC/LATINO ____

PRIMARY LANGUAGE: _____

PRIMARY PHYSICIAN: _____ TELEPHONE#: _____

REFERRING PHYSICIAN: _____ TELEPHONE#: _____

EMPLOYER NAME: _____ OCCUPATION: _____

WORK ADDRESS: _____ CITY, STATE: _____ ZIP: _____

POLICY HOLDER (NAME): _____
(Last) (First)
SOCIAL SECURITY #: _____ BIRTHDATE: _____

PHARMACY INFORMATION:

NAME: _____ TELEPHONE #:_____

ADDRESS: _____

IN CASE OF EMERGENCY: NOTIFY:_____TELEPHONE#:_____

PLEASE GIVE INSURANCE CARDS TO THE RECEPTIONIST TO BE COPIED.

ASSIGNMENT OF BENEFITS:
I authorize payment of medical benefits to myself or the named provider for professional services rendered.

SIGN: _____

RELEASE OF INFORMATION:
I authorize the release of any medical information necessary to process this claim

SIGN: _____

WE DO NOT RENDER CARE SIMPLY TO COLLECT MONEY, BUT WE MUST COLLECT MONEY TO CONTINUE RENDERING CARE. In the event that any balance remain unpaid, I will be responsible for expenses associated with collection, including reasonable attorney's fee and/or court costs.

_____
(Patient's Signature or Parent if Minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.

Patient's Date of Birth: _____

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CONSENT TO TALK ABOUT BILLING ISSUES

In case the staff needs to discuss insurance issues, or any issues related to a balance due on a bill:
I give permission to talk to the following:

_____ Spouse Name: _____

_____ Other Name: _____

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NO SHOW POLICY

Dear Patient:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor. Please let this notice serve to notify you that if you fail to give us a 24 hour notice of cancellation, there will be a $25.00 cancellation fee.

Signature of Patient: _____ Date: _____

CONSENT FOR NOTIFICATION OF BLOOD TEST/PATHOLOGY RESULTS

Patient Name: _____ DOB: _____

Telephone numbers for notification of results: _____

In case Doctor and/or staff cannot contact me for results, please communicate with:

_____ Spouse

_____ An Answering Machine

_____ Other

_____ _____

Patient's Signature Date

Dermatology Consultants of Broward
COSMETIC INTEREST QUESTIONNAIRE (OPTIONAL)

Patient Name: _____ DOB:_____

Date of Birth: _____ Sex: Male _____ Female _____

Address: _____

_____

Phone: _____ Email Address: _____

Fax: _____

Cosmetic Areas of interest to you (please check all that apply)

_____ Acne Treatments
_____ Chemical Peels
_____ BOTOX Cosmetics Injections
_____ Earlobe Repair
_____ Facial Rejuvenation Programs for sun damage, fine lines, and uneven pigmentation
_____ Fillers for fine lines and wrinkles
_____ Laser Treatments for red or brown spots
_____ Laser Hair Removal (what area) _____
_____ Physician dispensed Skin Care Products
_____ Skin Tag or Mole Removal
_____ Spider Vein Treatments
_____ Sun Care Advise
_____ Tattoo Removal
_____ Other, Please Specify: _____

_____ _____
Patient's Signature Date