Coralwood Dermatology, P.A.

Janet Cheng, MD

Patient Registration

Chart #_____

Mr., Mrs., Ms., Miss, Dr. _____

First **MI** **Last**

Date of Birth: _____/_____/_____ Gender: Male / Female

Married Single Divorced Widowed

Ethnic Group: Hispanic or Latino / non- Hispanic or Latino / Unknown / Decline

Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / White / Other Race / Decline

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____-_____-_____ Preferred Language: _____

Emergency Contact Name: _____ Contact Number: _____

Are you a full time Florida resident? **No / Yes** **(If part time Florida resident, please provide alternate address below)**

Alternate Address: _____ City / State: _____

Zip Code: _____

Email Address: _____@_____

What is the best way for us to contact you? **(Please provide a check mark next to your preferred phone number)**

Home Phone Number: (_____)_____-_____ ☐

Cell Phone Number: (_____)_____-_____ ☐

Primary Insurance

Policy Holders Name: _____ Policy Holders DOB: _____/_____/_____

Policy Holders address: _____ City: _____ State: _____ Zip: _____

Company Name: _____ Policy #_____

Policy Holders Social Security #: _____ (Required for filing insurance claims)

Patients relationship to Policy Holders **(please circle one)**: **SELF / SPOUSE / CHILD**

CONTINUE TO NEXT PAGE

Secondary insurance (if applicable)

Company name: _____ Policy # _____

Policy Holders Name: _____ Policy Holders DOB: _____/_____/_____

Policy Holders address: _____ City: _____ State: _____ Zip: _____

Policy Holders Social Security #: _____ (Required for filing insurance claims)

<u>If we are calling with Biopsy or Lab Results:</u>

May we leave a detailed message with your results with a member of your household? **Yes / No**

If **Yes** with whom? _____
Name/Relationship

May we leave a detailed message with your results on your voicemail/answering machine? **Yes / No**

<u>If you choose No to both of the above or leave blank, we will leave a message (without details) asking you to call our office back.</u>

Primary Care/Family Physician: _____

Referring Physician (if applicable): _____

Provide us with your Pharmacy's name, location and phone number:

_____

<u>If the patient is under the age of 18, parent/legal guardian's name and Social Security number must be given:</u>

Parent/Legal guardian's name: _____ Relationship: _____

Social Security Number of parent/legal guardian: _____

Date of Birth of parent/legal guardian: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

Past Surgical History

Have you had any of the following surgeries?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Both)
- ☐ Breast: Mastectomy (Right, Left, Both)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Both)
- ☐ Joint Replacement: Knee (Right, Left, Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Liver Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ OTHER _____

CONTINUE TO NEXT PAGE

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Mole
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other _____

Do you wear Sunscreen?

○ Yes ○ No If **YES**, what SPF? _____

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Melanoma?

○ Yes ○ No If **YES**, which relative?_____

Family Medical History

Please include only first-degree relatives:

_____ _____ _____

_____ _____ _____

Do you feel safe at home? **YES / NO**

IV Drug Use **YES / NO**

Date of last flu vaccination: _____/_____/_____ **Date of last pneumonia vaccination:** _____/_____/_____

How often do you exercise? Once a day / Few times a week / Few times a month

Smoking Status: Current smoker / Former smoker / Never smoke **Number of years smoking**: _____

CONTINUE TO NEXT PAGE

Allergies

List all allergies:

Allergies:		

Medications

List all current medications including dosage and frequency. Please include blood thinners and any supplements or vitamins:

Name of medication	Dose	Frequency

CONTINUE TO NEXT PAGE

Release of Information

(All Patients or Parent/Legal guardian must Sign)

I **authorize** the release of medical information to my **Primary Care** or **Referring Doctor, Laboratories**, **Pharmacies** and as necessary to **Insurance Companies** to process insurance claims, insurance applications, record of treatment and prescriptions. I understand that I am ultimately responsible for any and all services to me at the time of service.

I do here by give permission for Coralwood Dermatology, P.A. to release my protected health information to the Doctors listed below:

- _____ Phone: _____ Fax: _____
- _____ Phone: _____ Fax: _____
- _____ Phone: _____ Fax: _____

Please list below any person that you give permission to pick up prescriptions or any protected health information if you are unable to. This person will need to provide us with an ID card when picking up any information mentioned above. (You have the right to revoke this authorization at any time. Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.)

I do here by give permission to Coralwood Dermatology, P.A. to release my prescription or any protected health information to:

- _____, ____/____/____.
  Name of authorized person DOB of authorized person
  Relationship to Patient: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ FRIEND ☐ OTHER _____

- _____, ____/____/____.
  Name of authorized person DOB of authorized person
  Relationship to Patient: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ FRIEND ☐ OTHER _____

Notice of Privacy Practice - A Notice of Privacy Practice is available for your review. If you would like to have/read a copy, please ask the front desk for your copy.

- I have (1) received a copy of the Notice of the Privacy Practices or (2) have been offered a copy of the Notice of the Privacy Practice but declined to accept a copy.

I hereby certify that I have read, understood and provided the correct and legal information above.

Signature of Patient or Parent/Legal Guardian: _____

Date: _____/_____/_____

Signature of Authorized Employee: _____

Date: _____/_____/_____

CONTINUE TO NEXT PAGE

CORALWOOD DERMATOLOGY, PA

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

IF YOU ARE 15 MINUTES LATE TO YOUR APPOINTMENT IT WILL NEED TO BE RESCHEDULED.

NO SHOW POLICY- YOU ARE RESPONSIBLE TO CALL THE OFFICE TO EITHER CANCEL OR RESCHEDULE AN APPOINTMENT 24 HOURS IN ADVANCE. IN THE EVENT OF A NO SHOW, A FEE of $50.00 WILL BE CHARGED AND AT THE PHYSCIANS DISCRETION YOU MAY BE DISMISSED FROM OUR PRACTICE.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE- Payment is required at the time Services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. ***CORALWOOD DERMATOLOGY, PA*** accepts cash, personal checks, Visa, MasterCard, American Express and Discover. There is a service charge for returned checks of $20.00.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. In such circumstances, we may advise you to speak with our billing office to make arrangements for payment.

PATIENT RESPONSIBILITY -It is the patient's responsibility to provide ***CORALWOOD DERMATOLOGY, PA*** the current insurance coverage information prior to the visit. We are not responsible for benefits subject to the deductible or non-covered benefits.

MANAGED CARE -If you are enrolled in a managed care insurance plan (i.e., HMO), you will need to obtain a referral and or authorization from your PCP office before seeing a specialist. REFERRALS/AUTHORIZATIONS are not guaranteed.

INSURANCE -We bill participating Insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

For self-pay patients, with NO insurance coverage, we have self-pay rates that must be paid in full at time of service.

If you need assistance or have questions, please contact the Billing Office between 8:00AM and 4:00 PM, Monday through Friday at 239-458-1131 EXT 31

I have read and understand the ***CORALWOOD DERMATOLOGY, PA*** financial policy. I agree to assign insurance benefits to ***Coralwood Dermatology, PA*** wherever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the costs of collections.

Print Patient's Name: _____ DOB: _____

Signature of Patient/Guarantor: _____ Date: _____

Office use only: _____ Date: _____

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CONTINUE TO NEXT PAGE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by ***CORALWOOD DERMATOLOGY***, and of your individual rights and ***CORALWOOD DERMATOLOGY*** legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health information:

I may use and disclose at my discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing DERMATOLOGY care and related services.
- **Payment** means activities such as obtaining payment for the DERMATOLOGY care services I provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.
I will use and disclose your protected health information when required by federal, state or local law. Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing a I am required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.