

MacInnis Dermatology – New Patient Registration Form

27950 US Hwy 27
Leesburg, FL 34748

17521 US Hwy 441 Ste 21
Mt Dora, FL 32757

1950 Laurel Manor Drive, Ste 124
The Villages, FL 32162

Phone (352) 350-5230

Fax (866) 539-7193

Patient Information

(please complete using your name as listed on your insurance card) DATE _____

Patient First Name: _____	MI: _____	Last Name: _____
Address: _____		
City: _____	State: _____	Zip: _____
Date of Birth: ____/____/____	SS#: _____-_____-____	
Home Phone: _____-_____-_____	Cell Phone: _____-_____-_____	
Best # to confirm appointment: Home or Cell		
Do we have your permission to leave a voice message regarding your appointment? YES NO		
Email Address: _____		
Occupation: _____	Employer: _____	

If Patient is a Minor, Please Complete

Person Responsible or Guardian: _____	Date of Birth: _____
SS #: _____-_____-_____	Phone # (if different) _____-_____-_____
Home Address: _____	City: _____ State: _____ Zip Code: _____

Please Circle

Marital Status: Single Married Significant Other/Domestic Partner Divorced Widowed Birth Sex: M or F
Do you identify as anything other than your Birth Sex? Y or N If yes what do you identify as? _____
Language: English Spanish Other: _____
Race: White Black/African American Asian American Indian Other Race _____
Ethnic Group: Hispanic/Latino Not Hispanic/Latino Unknown _____

Seasonal Mailing Address

Start & End Dates: _____ to _____

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Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____
 Policy # / Member ID #: _____ Group #: _____
 Policy Holder: _____ DOB: ____/____/____
 Relationship: _____
 Insurance Address: _____

Secondary Insurance: _____
 Policy # / Member ID #: _____ Group #: _____
 Policy Holder: _____ DOB: ____/____/____
 Relationship: _____
 Insurance Address: _____

How did you hear about us: (Please select one)

Primary Care/Referring Physician: _____ Phone#: _____

Patient/Friend/Family Insurance Newspaper: _____ Other: _____

****HIPAA POLICY**** - Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of MacInnis Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA form.

If no one will be added, please print NONE

Name of individual (Please Print)	Relationship to Patient
_____	_____
_____	_____

Patient Signature: _____ **Date:** _____

MacInnis Dermatology – Consent Form

Please initial and sign at the bottom

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Initials	<p>Consent for treatment – I voluntarily consent to receive medical and health care services by Dr. Colleen MacInnis and/or her assistants that may include examinations, routine office procedures, diagnostic procedures, and other treatments deemed necessary by Dr. MacInnis. I agree to communicate any questions or concerns about my treatment to Dr. MacInnis prior to being treated. I agree to inform Dr. MacInnis before services are rendered about any health problems I may have, possible drug allergies, current medications I am taking, or any other information that may be pertinent to my treatment.</p>
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Initials	<p>Team Approach to Treatment – I understand that at MacInnis Dermatology we have a Certified Physician’s Assistant (PA-C) on staff. The relationship between a PA-C and the supervising physician is one of mutual trust and respect. The Physician Assistant is a representative of the physician, treating the patient in the style and manner developed and directed by the supervising physician. The physician and PA practice as members of a medical team in the delivery of medical care.</p>
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Initials	<p>No Guarantees – I understand that the practice of medicine is not an exact science and results vary among patients. I understand there is no contract, warranty, guarantee or promise concerning the results of medical services provided by Dr. MacInnis and/or her assistants.</p>
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Initials	<p>Limited Release of Information – I authorize the release of medical information to my primary care or referring physician, to consult if needed and as necessary to process insurance claims, insurance applications and prescriptions.</p>
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Initials	<p>Assignment of Benefits – I authorize MacInnis Dermatology to accept assignment/payment from my insurance carrier(s) for services rendered. I authorize use of my signature below on all my insurance submissions.</p>
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Initials	<p>Pathology Services for non-Medicare patients – I authorize Dr. MacInnis and/or her assistants at MacInnis Dermatology to send my tissue or other specimens to CarePath DX or other laboratories for microscopic slide processing and interpretation. I authorize representatives of MacInnis Dermatology to bill my insurance carrier for all pathology services performed by outside laboratories.</p>

I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

_____ **Patient Signature**

_____ **Date**

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MacInnis Dermatology - Financial Policy

I understand and agree to the following terms of MacInnis Dermatology's financial policy:

- Payment is due in full at the time of service for self-pay patients and for cosmetic procedures.
- We bill insurance as a courtesy, and balances are ultimately the patient's responsibility. If we cannot collect insurance payment within 90 days, the balance will be assigned to the patient.
- Co-payments and co-insurance (where a percentage of charges is assigned to the patient) are due at the time of visit.
- Patients must provide proof of insurance at the time of visit. If the patient's insurance card is not presented when there is a change in coverage, the patient will be responsible for full payment at the time of service.
- Patients are responsible for knowing their insurance coverage and benefits. Although we make every attempt to accurately confirm our participation in various plans, it is ultimately the patient's responsibility to verify coverage. We recommend calling your insurance carrier prior to your visit to verify coverage. Rejection of all or part of your medical insurance claim by your insurance company does not relieve your financial obligation to MacInnis Dermatology.
- Payment for patient bills is due upon receipt. After we receive insurance payment, there may be a remaining patient balance for deductibles, additional co-payments, non-covered services or any other charge the insurance carrier may assign to the patient. Payment is due immediately upon receiving a bill from MacInnis Dermatology.
- Prior balances are due at the time of visit. Returning patients must pay their bill if they arrive for an appointment and have an outstanding balance on their account.
- Accounts not paid within 120 days will be sent to a collection agency, and may subject to an additional 35% added fee of total balance.
- Missed appointments are subject to a \$50.00 cancellation fee. Please provide at least 24-hours advance notice if you need to reschedule or cancel your appointment.
- Missed surgery appointments are subject to a \$150.00 cancellation fee. Please provide at least 24-hours advance notice if you need to reschedule or cancel your appointment.
- MacInnis Dermatology accepts cash, checks and all major credit cards. If a check payment is returned by the bank, a \$25.00 fee will be applied to the patient's account. Patients who have a returned check must use cash or credit card only for all future payments.

Patient or Responsible Party Signature

Print Name

____/____/____
Date

Patient Intake Form

Name: _____ Date of Birth _____ Date: _____

Preferred Pharmacy

Name: _____ Phone: _____ City _____

Preferred Laboratory to Send Specimens

Name: _____ Please note: We use CarePath for our specimens. Results may take 2-3 weeks to come back. All benign results will be posted to the patient portal. You will be contacted **ONLY** if you need to schedule treatment

Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Enlargement of prostate
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD

- Hearing Loss
- Hepatitis
- High Blood Pressure
- HIV / AIDS
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

NONE

Other

Please turn page over

Past Surgical History

Have you had any surgeries on the following organs?

- | | |
|---|--|
| <input type="checkbox"/> Heart: Pacemaker | <input type="checkbox"/> Colon: _____ |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Liver: _____ |
| <input type="checkbox"/> Breast: Lumpectomy (Right Left Bilateral) | <input type="checkbox"/> Kidney: _____ |
| <input type="checkbox"/> Breast: Mastectomy (Right Left Bilateral) | <input type="checkbox"/> Ovaries: _____ |
| <input type="checkbox"/> Gallbladder: _____ | <input type="checkbox"/> Prostate: _____ |
| <input type="checkbox"/> Joint Replacement: Knee (Right Left Bilateral) | <input type="checkbox"/> Uterus: _____ |
| <input type="checkbox"/> Joint Replacement: Hip (Right Left Bilateral) | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Other: _____ | |

Skin Disease History

Have you had any of the following?

- Acne
- Actinic Keratosis
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever / Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- NONE
- 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?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other:

If any skin cancers please list location and date skin cancer. _____

Medications

List all current medications within the chart below;

Name of medication	Unit	Route (Oral, Injection etc.)	Dosage	Form (Pill, Cream, etc)	Frequency (How often)
1.					
2.					
3.					
4.					
5.					
6.					

Can we import medications from your pharmacy? Yes No

Any Known Drug Allergies

List all drug allergies if known:

Social History

Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Number of days in the past year you had Alcohol (please choose):

- None
- 1-3 per day, on _____ occasions in a year
- 4+ per day, on _____ occasions in a year
- 5+ per day, on _____ occasions in a year

Please turn page over

Family History of Skin Cancer

Please include only first-degree relatives:

Other Medical

Have you had the Pneumonia vaccine?

Yes No

Do you have advanced care planning in place?

Yes No

Do you have a healthcare surrogate?

Yes No

If yes, Provide the name of your surrogate.

Have you had the Influenza vaccine?

Yes No

If no, please explain: Allergy or
Other _____