John Morello MD Atlantic Boulevard Dermatology, 13111 Atlantic Blvd, Unit 4, Jacksonville, FL 32225, Tel 904 221 3100

Dearest patient: In order for us to best serve you, to file your insurance claims correctly, to be in compliance with federal and state law, and to meet requirements of Dept. of Health and Human Services. Please answer each question clearly and thoroughly. We appreciate your patience and apologize for any inconvenience.

Today's Date (mm/dd/yyyy): _____ / _____ / _____

PATIENT INFORMATION

Last Name:_____ **First Name**: _____ **Middle** _____

Date of Birth (mm/dd/yyyy): _____/_____/_____ Last 4 digits of SS#_____

Sex: ☐ M ☐ F Marital status (circle): Sgl. Mar. Sep. Div. Wid.

Cell Phone # _____ Home Phone # _____

Email Address (REQUIRED) _____@_____

Home Address: _____

Home Address: city _____State_____ Zip_____

Emergency Contact Name: _____ Phone# _____Relationship_____

Primary Care Doctor: Last Name _____ First Name_____ Phone # _____

Pharmacy Name & location: _____ Pharmacy Tel Number_____

Where do you work? _____ What profession?_____

INSURANCE INFORMATION:	**Primary Insurance**	**Secondary Insurance**
Insurance Co. name**:**	_____	_____
Insured Name (Last, First)	_____	_____
Insured DOB (mm/dd/yyyy**)**	_____	_____
Insured SS#	_____	_____
Insured relationship to patient**:**	_____	_____
Insurance policy ID#	_____	_____

ALLERGIES TO MEDICATION: ☐ NO ☐ Yes (If yes please list)_____

Describe allergy symptoms: _____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Childhood ☐ Adult ☐ Unknown

Have you been seen by Dr. Morello before? ☐ NO ☐ Yes

Reasons for todays visit: _____

Whom may we thank for referring you (Full Name)**:**_____

Are you on blood thinner medication? ☐ NO ☐ Yes (please list)_____

Do you have artificial heart Valve, pacemaker, mitral valve prolapse, artificial joint ? please circle all that apply.

Pregnant? ☐ Yes ☐ NO Nursing? ☐ Yes ☐ NO Currently on Birth control pills? ☐ Yes ☐ NO

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Patient Last Name: _____ **First Name:** _____ **Middle** _____

Personal History (check all that apply)

☐ Acne
☐ Eczema
☐ Dry skin
☐ Psoriasis
☐ Abnormal moles
☐ Skin Cancer
☐ Melanoma
☐ Sinusitis
☐ Herpes Zoster
☐ Rosacea
☐ Keloid
☐ Hypertension
☐ Stroke
☐ Diabetes
☐ Hepatitis/liver disease
☐ Kidney disease
☐ Thyroid Disease
☐ HIV disease
☐ Asthma
☐ Hay fever
☐ Depression
☐ Mental illness

Do you require antibiotics before dental work? ☐ Yes ☐ NO

List previous hospital admissions, medical, surgical and mental health, including year and reason for admission:

_____

Family History of Skin Cancer ☐ None ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other, specify_____

What Type of Skin Cancer? ☐ Melanoma ☐ Basal Cell ☐ Squamous Cell

Other Family History: ☐ Psoriasis ☐ Asthma ☐ Eczema ☐ Sinusitis ☐ Allergies ☐ Hay fever

Demographic and Population Health Information (required by Dept. of HHS)

Race:
☐ African or African American
☐ Asian or Asian American
☐ Caucasian or European American
☐ Hispanic
☐ Native American or Native Alaskan
☐ Native Hawaiian or Other Pacific Islander
☐ Other

Do you take any prescription or non-prescription medications including over the counter, herbal, vitamins ?

☐ NO ☐ Yes (list all, attach extra sheet if necessary) ☐ update any new medications since last visit

Name	Dosage	Frequency	Route of Administration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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In order to be in compliance with federal and state law and to meet HIPPA and MIPS requirements, please answer each question. We appreciate your patience and apologize for any inconvenience.

Patient Last Name: _____ **First Name**: _____ **Middle** _____

Tobacco Usage:

- ☐ Never
- ☐ Former
- ☐ Current

What type of tobacco:

- ☐ Cigarettes
- ☐ Chewing Tobacco

****

If you are 65 years or older please answer the following:

Pneumonia Vaccination Status:

- ☐ Yes, I have previously received Pneumococcal Vaccine.
- ☐ NO, I have not previously received Pneumococcal Vaccine.

Advance Care Plan status:

- ☐ I do not wish or not able to name a surrogate decision maker or provide an advance care plan.
- ☐ I have an advance care plan & a surrogate decision maker. His/ Her name: _____
- ☐ NO, I do not have an advance care plan.

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This box is for Atlantic Boulevard Dermatology office staff only:

Tobacco use screening & cessation intervention as per Dept. of Health & Human Services MIPS Guidelines.

Advance care planning discussed as per per Dept. of Health & Human Services MIPS Guideline.

office staff initials _____

ATLANTIC BOULEVARD DERMATOLOGY

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____ have received a copy of Atlantic Boulevard

Dermatology's Notice of Privacy Practices.

_____ _____

Signature of patient Date

Atlantic Boulevard Dermatology

Financial Policy

Because of the confusing changes in healthcare and the insurance coverage of many health plans, we feel it is important that you fully understand our financial policy prior to your appointment in order to avoid misunderstandings.

All new patients are asked to fill out a new patient information form and provide us with the necessary insurance and identification cards required to allow our billing service to process insurance claims. Some insurance may also require the patient to have an appropriate referral from their primary care physicians.

We do not accept Medicaid as either a primary or secondary insurance. Medicare patients are responsible for their copays and deductibles at the time of service unless they have a secondary insurance other than Medicaid, which will cover the office visit.

We verify insurance on all new patients. For procedures that may be covered by your insurance, we will assist you by filing your insurance claim. Payment by your insurance company is your responsibility. We will allow 45 days for your insurance company to pay your claim. If you are unable to provide us with the necessary insurance or referral information, you will be expected to pay for the office visit and we will provide you with a copy of the bill that you may submit to your insurance company to attempt to obtain reimbursement from them. Follow-up patients are required to provide us with any changes of insurance information prior to their visit.

All payments including copays or unpaid deductibles are expected at the time of service. For your convenience we accept cash, debt, Visa, or Mastercard. If your insurance deductible is not met, we charge a minimum fee as a deposit, and then may bill you the balance owed based on your insurance fee schedule allowables.

There is a $50 charge for ALL returned checks. If the account should be sent to collection, the patient will be responsible for any collection fees or attorney fees.

You agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 54% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.

Please read, sign, and date:

1) I authorize Atlantic Boulevard Dermatology to release information to my insurance company to bill my insurance company direct for services rendered.
2) I authorize my insurance benefits to paid directly to Atlantic Boulevard Dermatology and I assume responsibility for deductibles and non-covered services.
3) In the event that I receive payment from my insurance company for services billed, I agree to pay the full amount of payment to Atlantic Boulevard Dermatology.
4) I understand my copays is due at the time of service.

_____ _____ Date: _____

(patient name-printed) (signature-responsible party)