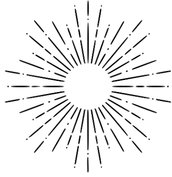


North Florida Dermatology

New Patient Registration

Last Name: ________________________ **First Name:** ________________________ **Middle:** ___________ **Suffix:** _______
Nickname: _________________________

Marital Status:

☐ Divorced ☐ Married ☐ Single ☐ Widowed

Date of Birth: _______/_______/________ **Gender:** _____________ **Preferred Language:** ______________________________

Ethnic Group:

☐ Decline to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race:

☐ Decline to specify ☐ Black or African American ☐ White ☐ Asian ☐ Other: _________________

Preferred Contact Method:

☐ Patient Portal ☐ Phone ☐ Email ☐ Letter

Emergency Contact

Name: _______________________________ Phone Number: ______________ Relationship to Patient: _______________

For minors

Legal Guardian: _________________________ Phone Number: ______________ Relationship to Patient: _______________

Phone Numbers ***(please place a check by your preferred number)***

☐ Home: ______________________ ☐ Work: _______________________ ☐ Mobile: ______________________

May we leave a detailed message (with protected health information such as results, etc.) at your phone number? ☐ Yes ☐ No

Email Address: ____

Home Address: ____________________________ **City:** _______________________ **State:** _______ **Zip Code:** ___________

Employer: ____ **Occupation:** _____________________________________

Insurance Information

Primary Policy

Payer (Insurance Company): ______________________ Policy Number: ____________________ Group Number: ___________

Policy Holder Name: _________________________________ **Patient's Relationship to Policy Holder:** _______________

Policy Holder Date of Birth: ________/_________/___________ **Policy Holder Gender:** _____________________________

Secondary Policy

Payer (Insurance Company): ______________________ Policy Number: ____________________ Group Number: ___________

Policy Holder Name: _________________________________ **Patient's Relationship to Policy Holder:** _______________

Policy Holder Date of Birth: ________/_________/___________ **Policy Holder Gender:** _____________________________

Pharmacy and Referral Information

Pharmacy Name: _______________________ Location: ___________________ Phone Number: _____________________

Primary Care Provider: ____

Past Medical History

Please tell us about your medical history. Check all that apply:

- ☐ NONE
- ☐ Anxiety disorder
- ☐ Arthritis – Osteoarthritis
- ☐ Arthritis – Psoriatic arthritis
- ☐ Arthritis – Rheumatoid arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident (stroke)
- ☐ Chronic kidney disease
- ☐ Chronic obstructive lung disease
- ☐ Coronary artery disease
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Hearing Loss
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Malignancy – Lung cancer
- ☐ Malignancy – Breast cancer
- ☐ Malignancy – Colon cancer
- ☐ Malignancy – Prostate cancer
- ☐ Multiple sclerosis
- ☐ Myocardial infarction (heart attack)
- ☐ Systemic lupus erythematosus
- ☐ Other ____________________

Past Surgeries

Please tell us about your surgical history. Check all that apply:

- ☐ NONE
- ☐ Appendectomy
- ☐ Breast biopsy
- ☐ Breast lumpectomy (☐ left ☐ right)
- ☐ Breast mastectomy ((☐ bilateral ☐ left ☐ right)
- ☐ Breast augmentation
- ☐ Cardiac catheterization
- ☐ Coronary artery stent
- ☐ CABG (Coronary artery bypass graft)
- ☐ Cataract surgery
- ☐ Cesarean section
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Colostomy
- ☐ Heart valve replacement
- ☐ Hysterectomy
- ☐ Hip replacement ((☐ bilateral ☐ left ☐ right)
- ☐ Knee replacement (☐ bilateral ☐ left ☐ right)
- ☐ Kidney biopsy
- ☐ Oophorectomy
- ☐ Prostate biopsy
- ☐ Prostatectomy
- ☐ Radiation therapy
- ☐ Splenectomy
- ☐ Skin biopsy
- ☐ Skin – Excision of basal cell carcinoma
- ☐ Skin – Excision of melanoma
- ☐ Skin – Excision of squamous cell carcinoma
- ☐ Tonsillectomy
- ☐ Transplant of bone marrow
- ☐ Transplant of heart
- ☐ Transplant of kidney
- ☐ Transplant of liver
- ☐ Transplant of lung
- ☐ Tubal ligation
- ☐ Other _________________________________

Gynecologic History (Optional)

Last mammogram: ____/____/____

Last menstrual period: ____/____/____

Last Pap smear: ____/____/____

Last pelvic exam: ____/____/_____

Obstetric History (Optional)

Number of pregnancies: _______

Number of delivered pregnancies: _______

Number of miscarriages: _______

Number of abortions: _______

Pediatric History (Pediatric Patients Only)

Gestational Age at Birth: _______ wks Birth Weight: ______lbs ______oz Maternal Illness during Pregnancy? ______________

Skin Disease History

Have you had any of the following conditions?

- ☐ NONE
- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Atypical fibroxanthoma
- ☐ Basal Cell Skin Cancer
- ☐ Contact dermatitis to poison ivy
- ☐ Atypical moles
- ☐ Eczema
- ☐ Melanoma
- ☐ Merkel cell carcinoma
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ Sunburn (blistering)
- ☐ 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? _______________

Medications

Please list all medications you are currently taking:

☐ No medications

Medication Name	Dose	Route (oral, subcutaneous, etc.)	Frequency (daily, twice a day, nightly as needed, etc.)

Allergies

Please list all known drug allergies, as well as the type of reaction and level of severity:

☐ No known drug allergies

Allergy	Reaction (if known)	Severity (if known)

Social History

Smoking Status:

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Current Some Day Smoker
- ☐ Current Every Day Smoker

If applicable:

When did you start smoking? ____/____/____ Number of packs per day: ________

When did you quit smoking? ____/____/____ Total number of years smoking: ________

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

For men age 65 or younger, how many times in the past year have you had 5 or more drinks in a day? __________

For women or any adult older than 65, how many times in the past year have you had 4 or more drinks in a day? _________

Other details:

- ☐ Not Sexually Active
- ☐ Sexually Active (One Partner)
- ☐ Sexually Active (Multiple Partners)
- ☐ Illicit drug use

How often do you exercise?

- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never

Have you received the pneumonia vaccine? ☐ Yes ☐ No

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No

☐ Designee's name _______________________ ☐ Phone number _______________________

Do you have a living will? ☐ Yes ☐ No

Which statement best reflects your wishes on advanced care recommendations?

- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Family History

Please list any family history of illness or disease:

Family Member	Illness or Disease
Mother	
Father	
Sister	
Brother	
Daughter	
Son	

Please let us know if there is anything else you would like to disclose:

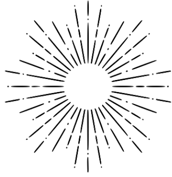
____

____

What issues would you like addressed at your first appointment?

____

____



Authorization to Disclose Protected Health Information (PHI)

Please complete this form if you would like for us to be able to share protected health information (such as biopsy results, etc.) with another person.

Patient Name: ____Date of Birth: _______/_______/_________

By signing this form, I authorize the release of protected health information as follows:

From

North Florida Dermatology
1717 SW Newland Way
Lake City, FL 32025
Phone: 386-344-6102
Fax: 386-344-6103

To

Last Name: ____First Name: ____

Home Phone: _______________________________________Mobile Phone: ____

Relationship to Patient: ____

Would you like this authorization to expire on a certain date? ☐ Yes ☐ No If yes, which date? _______/_______/____________

This authorization allows North Florida Dermatology to use and disclose (release) certain PHI, which includes medical records, as I have directed.

I understand that:

- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect until the date specified above or, if no date is specified, until I revoke it in writing.
- I have the right to revoke this authorization at any time, if I do so in writing to North Florida Dermatology and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.

Patient Signature: ____Date: _______________________________

or

Legal Representative Signature: ____ Date: _______________________________

Relationship to Patient: ____