

EMERALD COAST DERMATOLOGY & SKIN SURGERY CENTER, PA

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Destin, FL 32541
(850) 654-3376
Fax 654-3320

930 Mar Walt Dr, Suite C
Fort Walton Beach, FL 32547
(850) 314-7546
Fax 314-7542

Welcome to our office. In order to serve you properly, we will need the following information. (Please Print) All information is strictly confidential. **Full Payment is expected when services are rendered.** Thank you for your cooperation.

PATIENTS NAME LAST, FIRST, MI	AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS S M OTHER	SEX MALE FEMALE
STREET ADDRESS		CITY, STATE, ZIP		HOME PHONE ()	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		EMPLOYER		WORK PHONE ()	
NEAREST RELATIVE: NAME, ADDRESS & PHONE NUMBER		EMAIL ADDRESS		CELL PHONE ()	

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	GUARANTOR PHONE NUMBER
PRIMARY INSURANCE COMPANY NAME		POLICY/ ID NUMBER	GROUP NUMBER
SECONDARY INSURANCE COMPANY NAME		POLICY/ ID NUMBER	GROUP NUMBER

MEDICAL INFORMATION

Reason for your visit today? _____ Drug Allergies _____

Please list of medications you are currently taking _____

Please list all major illnesses (high blood pressure, diabetes, etc) _____

Do you have a personal history of skin cancer? _____ Do you have a family history of skin cancer or melanoma? _____

Financial Policy

Your insurance policy is a contract between you and your insurance company. Emerald Coast Dermatology cannot guarantee payment for any claim. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT a substitute for payment. Many companies will pay only fixed allowances for procedures and others will pay a percentage of the charge. It is YOUR responsibility to pay any unmet deductible amount, co-insurance, or any other balance not paid by your insurance company. Professional fees for office service are expected in full at the time of service unless previous arrangements were made IN ADVANCE.

I, hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Emerald Coast Dermatology & Skin Surgery Center, P.A. I authorize release of medical records to my insurance carrier. When charges are filed with your insurance carrier with an assignment of benefits to our office, any fees unpaid *after 45 days will become the patient's responsibility*. In case of no insurance. I understand that I am solely responsible for all bills incurred and I am expected to pay when services are rendered. I understand that the removal of benign lesions (moles, barnacles, skin tags, etc) is considered a cosmetic procedure and is not subject to insurance payment. Therefore, fees are my financial responsibility.

Please Note: There will be a \$30.00 service charge for returned checks. We reserve the right to charge for appointment cancelled or broken without 24 hours of advance notice. How do you intend to pay? [] Check [] Cash [] Credit Card (MC/Visa, Discover, AMEX)

Signature of Patient

Date

Recommended By

PHARMACY	PHARMACY PHONE NUMBER
PRIMARY PHYSICIAN	PHONE NUMBER ()
PRIMARY PHYSICIAN ADDRESS	

PATIENT INFORMATION FORM

Aspirin/Motrin/Advil.....	YES	NO	Birth Control Pills....	YES	NO	Are you pregnant.....	YES	NO
Coumadin	<input type="checkbox"/>	<input type="checkbox"/>	Are you Breast Feeding....	<input type="checkbox"/>	<input type="checkbox"/>	Plan on becoming pregnant.	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS (Current or Past problems with)

Blood/Bleeding Disorders...	YES	NO	Arthritis	YES	NO	Cancer (non-skin).....	YES	NO
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Immunologic Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex/Nickel/Food Allergy..	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease or Hepatitis...	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease (TB, HIV)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorders...	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma.....	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU

Have a pacemaker/defibrillator	YES	NO	Have an artificial joint / heart valve.....	YES	NO
Take antibiotics prior to dental procedures.....	<input type="checkbox"/>	<input type="checkbox"/>	Form Keloids	<input type="checkbox"/>	<input type="checkbox"/>

List Surgeries:

Family History (Check the following medical conditions which have occurred in your family)

Disease	Mother	Father	Sibling	None	Disease	Mother	Father	Sibling	None
Acne.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Do you live alone?	YES	NO	Frequency _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Frequency _____
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	

Occupation _____ Hobbies/Leisure Activity _____

Patient Signature _____ Date _____