Gainesville Dermatology and Skin Surgery
114 NW 76th Drive
Gainesville, FL 32607
352-332-4442

INSURANCE INFORMATION

Policy Holder's name: _____

Date of Birth: _____ **Policy Holder SS#:** _____

Insurance Co. Name: _____

Insurance ID #: _____

FINANCIAL POLICY

All payments, including deductibles and co-pays, are required at the time of service. Returned checks are subject to a service charge of $35.00. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs and expenses, including reasonable attorneys fees, we incur in such collection efforts.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Gainesville Dermatology and Skin Surgery for services rendered by the physician or staff in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance or that my insurance company deems not reasonable or necessary including procedures deemed cosmetic in nature.

RISK OF PROCEDURES

I understand that all medical and surgical procedures carry some risks. These risks may include, but are not limited to, the following: If an area is treated with liquid nitrogen (cryotherapy, freezing) of TCA chemical peel, the risks of the treatment include discomfort or pain and a light white or pink scar. If a biopsy is performed, the risks of the procedure include a reaction to the anesthesia (Lidocaine with epinephrine) including anaphylaxis, a reaction to the topical antibiotic or bandage, infection, bleeding, scarring (possibly a white depressed scar or thick pink scar), or local change in skin color.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Gainesville Dermatology and Skin Surgery to release any medical or incidental information that may be necessary for either medical care or processing insurance claims.

AUTHORIZATION FOR TREATMENT

I hereby authorize Gainesville Dermatology and Skin Surgery staff and / or whomever they may delegate to provide medical, surgical, nursing, emergency care or such treatment as deemed necessary.

Patient Name (please print) _____ **Date:** _____
Parent Guardian (please print) _____
Signature of patient / guardian: _____

A photocopy of these assignments shall be valid as the original.

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ Cell Phone: _____

State : _____ Zip: _____ Alt. Phone: _____ Today's Date _____

SS#: _____

Employer: _____ Email Address: _____

Occupation: _____ Date of Birth: _____

Marital Status: _____ Referring Physician: _____

Emergency Contact: _____ Emergency Number: _____

How did you hear about our practice?: _____

Allergies to Medications: _____

Current Medications: _____

_____

Currently Using	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Aspirin / Motrin / Advil.....	☐	☐	Birth Control Pills.....	☐	☐	Are you pregnant?..... ...	☐	☐
Coumadin / Plavix.....	☐	☐	Are you breastfeeding.....	☐	☐	Plan on becoming pregnant?..	☐	☐

Skin Related Review of Systems (Current or past problems)

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Acne.....	☐	☐	Eczema (Atopic Dermatitis)..	☐	☐	Psoriasis.....	☐	☐
Precancerous Lesions (AKs).....	☐	☐	Efudex used for precancers..	☐	☐	Liquid Nitrogen for precancers.	☐	☐

Other Skin Problems: _____

Skin Cancers (non-melanoma)..... ☐ ☐ → Locations & Type: _____

Melanoma..... ☐ ☐ → Locations: _____

Review of Systems (Current or past problems)

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Asthma.....	☐	☐	Hay Fever (Allergic Rhinitis).	☐	☐	Arthritis.....	☐	☐
Blood / Bleeding Disorders.....	☐	☐	Diabetes.....	☐	☐	Heart Disease.....	☐	☐
High Blood Pressure.....	☐	☐	HIV or AIDS.....	☐	☐	Kidney Disease.....	☐	☐
Liver Disease or Hepatitis.....	☐	☐	Lung Disease.....	☐	☐	Lupus.....	☐	☐
Psychological Disorders.....	☐	☐	Cancers (non-skin):					
Thyroid Disease.....	☐	☐	Other Health Problems:					

Family History (Conditions that have occurred in your immediate family - parents, siblings, children)

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Eczema (Atopic Dermatitis).....	☐	☐	Hay Fever (Allergic Rhinitis).	☐	☐	Asthma.....	☐	☐
Lupus.....	☐	☐	Psoriasis.....	☐	☐	Melanoma.....	☐	☐

Personal History	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Live alone?.....	☐	☐	Drink alcohol?.....	☐	☐	→ Frequency:		
Use recreational drugs?.....	☐	☐	Smoke?.....	☐	☐	→ Frequency:		

Have a pacemaker / defibrillator?.....Yes ☐ No ☐ Need antibiotics prior to surgical / dental procedures?.....Yes ☐ No ☐

Patient Signature: _____ Date: _____