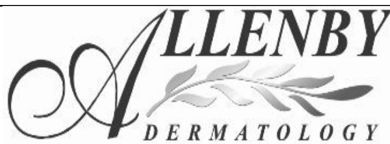


PATIENT MEDICAL HISTORY

Patient: ______________________________ **Date:** ______________

Reason for your visit today: ______________________________

CURRENT MEDICATION	**Y**	**N**	**If yes,**
Do you have any allergies to food or medicine?	☐	☐	Please list________________ (List more below)
Do you currently use any prophylactic antibiotics?	☐	☐	Please list________________ (List more below)
Do you drink alcohol?	☐	☐	What______________Amt per day________
Do you smoke?	☐	☐	
Do you currently use IV drugs?	☐	☐	What______________Amt per day________
Do you currently take any medications?	☐	☐	What______________________
Have you ever been exposed to HIV/AIDS?	☐	☐	Have you ever had a blood transfusion ☐Y ☐N
Have you ever had dental anesthesia (Novacaine)?	☐	☐	Any adverse reaction? ☐Y ☐N
Are you latex intolerant?	☐	☐	

SKIN	**Y**	**N**	**If yes,**
Have you ever had skin cancer?	☐	☐	Location(s) ______________________
Family history of skin cancer?	☐	☐	Relationship______________________

Relationship______________ Relationship______________ Relationship______________

Do you currently use skin care products?	☐	☐	What products______________________

When exposed to sun, do you ☐TAN ☐TAN & BURN ☐BURN

List any other disease or condition we should be aware of: ______________________________

List surgical procedures performed within the last 6 months: ______________________________

Do you have now, or have you ever had diseases or conditions of: (If yes, please check box)

LUNGS

☐ Bronchitis ☐ Emphysema ☐ Asthma ☐Chronic Cough ☐Morning Cough

VASCULAR

☐ High Blood Pressure ☐ Chest Pain ☐ Heart Attack ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Pacemaker
☐ Blood Clots/Phlebitis ☐ Mitral Valve Prolapse

OTHER SYSTEMIC

☐ Diabetes ☐ Thyroid ☐ Kidney ☐ Bladder ☐ Stomach ☐ Bowel ☐ Hepatitis A/B/C
☐Glaucoma ☐Arthritis/Joint

PLEASE ANSWER THE FOLLOWING QUESTIONS

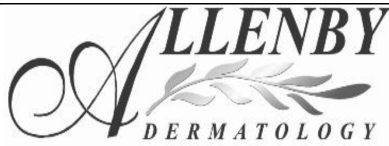
1. (Women) Are you pregnant? ☐Y ☐N If no, date of last menstrual period:___/___/_____
2. Do you bleed easily? ☐Y ☐N
3. Do you have artificial joint, pins or screws? ☐Y ☐N
4. Do you require antibiotics prior to surgery? ☐Y ☐N
5. What is your occupation? ______________________________

Referring Physician: ______________________________

Preferred Pharmacy______________________

Location:______________________________ **Phone:**____________________

MEDICATIONS		**ALLERGIES**	**PACEMAKER**
	❑ D/C		❑ YES ❑ NO
	❑ D/C		**PREMEDICATION**
	❑ D/C		❑ YES ❑ NO
	❑ D/C		**NOTES:**



PATIENT REGISTRATION

PLEASE PRINT CLEARLY

Patient Name ______________________________

Address ______________________________

City ______________ State ________ Zip ________

Home Phone ______________ Cell ______________ Ht ________ Wt ________

Social Security Number ______________ Race ________ Ethnicity ________

Date of Birth __________ Age ______ Marital Status __________ Language __________

Emergency Contact ______________________ Phone ______________

Primary Insurance ______________________ Begin Date: ______________

Policy Number ______________________ Group# ______________

Secondary Insurance ______________________ Begin Date: ______________

Policy Number ______________________ Group# ______________

How were you referred to our Office(Patient/Doctor) ______________________

Receive e-mail notifications: ______________________

ASSIGNMENT OF BENEFITS

1. Allenby & Associates, Dermatology Specialist Inc., ("Allenby Dermatology"), agrees that should a bill for medically necessary services be submitted to my carrier, and my carrier compensates Allenby Dermatology a lesser amount in total satisfaction of the services rendered, Allenby Dermatology will accept said payment and not seek the deficiency from me.
2. However, I recognize that some insurance carriers may pay a lesser amount for non-medically necessary services and I may be responsible to pay the difference. If my procedure is not fully covered by my insurance carrier, for example, but not limited to, non-medically necessary services, or I do not have a health insurance carrier which covers my medically necessary or non-medically necessary needs/requests, I agree to remit to Allenby Dermatology any and all payment for service performed on my behalf. I realize it is my obligation and responsibility to understand what services and payments my insurance carrier covers prior to receiving any services.
3. If paragraph 2 should apply, I agree to remit payment to Allenby Dermatology prior to or immediately after services performed that day. If Allenby Dermatology agrees to send me an invoice, I agree to remit payment within 10 days of receipt of said invoice. Should I not remit said payment, I agree that I will be in default of my obligations and Allenby Dermatology may seek the assistance of a collection agency and/or attorney to collect any and all outstanding balance owed. Any and all outstanding amounts due and owing shall accrue interest at a rate of 18% per annum. I agree to pay any and all additional sums expended for said collection, including but not limited to, cost of collection, collection expenses, reasonable attorney fees and cost, up to and including the appellate level. The parties agree that for the purposes of collection of any amounts due and owing, venue shall lie in Palm Beach, Broward or Miami-Dade Counties.

______________________________ ______________

Patient Signature *Date*

DOCUMENTS

1. I acknowledge that for security purposes Allenby & Associates, Dermatology Specialists Inc. may preserve any and all medical records and related documents by electronic scan and/or computerized means, and that the original physical documents may be destroyed.
2. I agree that any and all electronic formats (i.e. scanned) shall have the same legal and medical effect as destroyed originals.

______________________________ ______________

Patient Signature ***Date***

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent Allenby& Associates, Dermatology Specialists Inc., ("Allenby Dermatology"), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Allenby & Associates, Dermatology Specialists Inc. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to receive a copy of Allenby& Associates, Dermatology Specialists Inc., Privacy Practices at any time upon my request.

Allenby& Associates, Dermatology Specialists Inc., reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Allenby & Associates, Dermatology Specialists Inc. Privacy officer at:

6290 Linton Blvd. Suite 204
Delray Beach, Florida 33484

With my consent, Allenby& Associates, Dermatology Specialists Inc., may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Allenby & Associates, Dermatology Specialists Inc., may mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as patient statements.

I have the right to request that Allenby& Associates, Dermatology Specialists Inc., restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

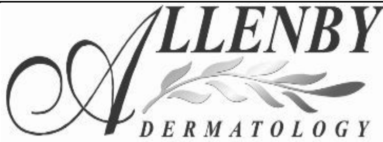
By signing this form, I am consenting to Allenby & Associates, Dermatology Specialists Inc. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Allenby & Associates, Dermatology Specialists Inc. may decline to provide treatment to me.

_______________________________________ _______________

Patient Signature *Date*

With my consent, Allenby& Associates, Dermatology Specialists Inc., may call my home, cell phone and leave a message with spouse and/or designated person listed: ________________________________



CONSENT FOR TREATMENT INSURANCE RELEASE/AUTHORIZATION

I give permission for Allenby & Associates, Dermatology Specialist, Inc to treat me, including any biopsy or procedure(s), as deemed necessary in the exercise of its professional judgment.

- I understand that medical care requires my cooperation and will follow orders and prescriptions provided by Allenby & Associates, Dermatology Specialists Inc. I will schedule and keep appointments for follow-up care, and if required to call any changes or concerns in my condition.
- I authorize Allenby & Associates, Dermatology Specialists Inc. to take photographs, video, or other similar means of record my surgical procedures. I understand that reproduction or publication of said photographs and recordings may be used for the purpose of medical or scientific study and research.
- I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedures and that every effort will be made to protect the patient’s identity in those materials.
- I further acknowledge that all recorded media obtained is the sole property of Allenby & Associates, Dermatology Specialist Inc.
- I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

______________________________________ ______________

Patient Signature ***Date***

AUTHORIZATION AND RELEASE

- I have read and understand the medical consent forms that Allenby & Associates, Dermatology Specialists Inc. has provided.
- I authorize Allenby & Associates, Dermatology Specialists Inc. to release any information, including but limited to, the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers, including Medicare.
- I authorize that Allenby & Associates, Dermatology Specialists Inc. may preserve any and all medical records and related documents by scanning said documents electronically/computerized and thereafter destroy all original paper documents.
- I authorize that any and all electronic/computer formats of my complete medical record have the same legal medical effect as the destroyed originals.

______________________________________ ______________

Patient Signature ***Date***

	NOTICE OF PRIVACY PRACTICES

1. The notice of privacy practices describes how Allenby& Associates, Dermatology Specialists Inc. ("Allenby Dermatology") may use and disclose Patient Health Information (PHI) to carry out treatment, payment and/or health care operations or any other specified purposes that are permitted or required by law.

2. **TREATMENT:** Allenby Dermatology may use your PHI to provide and coordinate the treatment, medications and services you receive.

3. **PAYMENT:** Allenby Dermatology may use your PHI for various payment-related functions, including, but not limited to, communication with your insurer, pharmacy, and/or any other health care payer.

4. Allenby Dermatology may disclose your PHI for the following purposes however, Allenby Dermatology may never have reason to make some of these disclosures:

a. **To communicate with individuals involved in your care or payment for your care.** Allenby Dermatology may disclose to family members, other relatives, close personal friends or any other person you identify, PHI directly relevant to that person's involvement in you care or payment related to your care.
b. **Food and Drug Administration (FDA**). Allenby Dermatology may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, food, supplements, products and product defects.
c. **Workers Compensation.** Allenby Dermatology may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
d. **Public Health.** As required by law, Allenby Dermatology may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability.
e. **Law Enforcement**. Allenby Dermatology may discuss your PHI for law enforcement purposes as required by law or in response to a subpoena or court order.
f. **As required by law**. Allenby Dermatology may disclose your PHI when required to do so by federal, state or local law.
g. **Health Oversight Activities.** Allenby Dermatology may disclose your PHI to an oversight agency for activities Authorized by law. These oversight activities include audits, investigations, inspections and credentialing as necessary to licensure and for the government to monitor the health care system, government programs, and compliance with civil rights law.
h. **Judicial and Administrative Processing.** If you are involved in a law suite or dispute, Allenby Dermatology may be forced to disclose your PHI in response to a court or administrative order. Allenby Dermatology may also be forced to disclose health information about you in response to a subpoena, discovery request, other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by requesting party or us, to tell you about the request or to obtain an order protecting the information request.
i. **Research.** Allenby Dermatology may disclose your PHI to a researcher if their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy or your information. Example: treatments.
j. **Coroners, Medical Examiners, and Funeral Directors.** Allenby Dermatology may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. Allenby Dermatology may also disclose PHI to a funeral director consistent with applicable law to enable them to carry out their duties.
k. **Organ or Tissue Procurement Organization.** Consistent with applicable law, Allenby Dermatology may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation and/or organs for the purpose of tissue donation and transplant.
l. **Notification.** Allenby Dermatology may use or disclose your PHI or notify or assist in notifying a family member, personal representative, or another person responsible for your care.
m. **Correctional Institutions.** If you are or became an inmate at a correctional institution, Allenby Dermatology may discuss with the institution or its agents PHI necessary for your health and the health and safety of other individuals.
n. **To Avert a Serious Threat to Health or Safety.** Allenby Dermatology may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
o. **Military and Veterans.** If you are a member of the armed forces, Allenby Dermatology may release PHI about you as required by military command authorities. Allenby Dermatology may also release PHI about foreign military personnel to the appropriate foreign military authority.

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p. **National Security, Intelligence Activities and Protective Services for the Present and Others.** Allenby Dermatology may release PHI about you to federal officials for intelligence, counterintelligence, protection to the President, and other national security activities authorized by law.

q. **Other Uses and Disclosures of PHI.** Allenby Dermatology may disclose PHI about you to a government authority if Allenby Dermatology reasonably believe you are a victim of abuse or neglect. Allenby Dermatology may only disclose this type of information to the extent required by law.

5. **Other Uses and Disclosures of PHI**. Allenby Dermatology will obtain your written authorization before using or disclosing your PHI for purposed other than those provided above. You may revoke an authorization in writing at any time. Upon receipt of your written revocation, Allenby Dermatology will stop using or disclosing your PHI, except to the extent that Allenby Dermatology has already taken action in reliance on the authorization.

6. **Request a Restriction on Certain Uses and Disclosures of PHI**. You will have the right to request additional restrictions on Allenby Dermatology use or disclosure of your PHI by sending a written request to the office. However, Allenby Dermatology **is** not required to agree to these restrictions. Allenby Dermatology cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.

7. **Inspect and Obtain a Copy of PHI.** In most cases, you have the right to access and copy the PHI that Allenby Dermatology maintains about you. To inspect or copy your PHI, you must send a written request to the office. Allenby Dermatology may charge a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. Allenby Dermatology may deny your request to inspect and copy under certain limited circumstances.

8. **Request an Amendment of PHI.** If you feel the PHI Allenby Dermatology maintain about you is incomplete or incorrect, you may request that Allenby Dermatology amend it. To request an amendment, you must send a written request to the office. You must include a reason that supports your request. In certain cases, Allenby Dermatology may deny your request for amendment.

9. **Receive an Accounting of Disclosure of PHI.** You have the right to receive an accounting of the disclosure Allenby Dermatology have made to your PHI after April 14, 2003, for most purposes other than treatment, payment, or health care operations. The right to receive an accounting is subject to certain exceptions, restrictions and limitations. To request an accounting you must submit a request in writing to the office. Your request must specify the time period. The time period may not be longer than 6 years and may not include dates before April 14, 2003.

10. **Request Communication of PHI by Alternative Means or at Alternative Locations.** You may request that Allenby Dermatology contact you at a different residence or post office box. To request confidential communication of your PHI, you must submit a request in writing to the office. Your request must tell us how or where you would like to be contacted. Allenby Dermatology will use its best efforts to accommodate all reasonable requests.

11. **Incidental Disclosure.** Allenby Dermatology will use its best efforts to avoid incidental disclosure or protected health information. An example of an incidental disclosure is conversations that may be overheard between staff and the physician.

12. **All Types of Insurance Companies.** Allenby Dermatology may disclose PHI to insurance carriers such as, but not limited to (Example: Auto, Homeowners, Life, etc.).

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