ROBERT J. SIRAGUSA, M.D.
Diplomate, American Board of Dermatology
CHARLES R. KOVALESKI, M.D.
Diplomate, American Board of Dermatology
CHARLES A. BYRON, PA-C, M.P.A.S.

DERMATOLOGY ASSOCIATES
SKIN & CANCER CENTER
(850) 769SKIN (7546) • Fax (850) 785-2123
1900 HARRISON AVE. • PANAMA CITY, FL 32405
www.769skin.com

KELLY C. WOOD, M.P.H., P.A.
BRET JOHNSON, M.D.
Diplomate ABFM, Specialty in Dermatology
NANCY WATSON, P.A.

PATIENT INFORMATION

Name _____
First MI Last Nickname

Date of Birth _____ Phone _____
Month Day Year

Social Security # _____ Cell _____ Work _____

Mailing Address _____

_____ Email _____
City State Zip

PRIMARY INSURANCE:

Carrier Name _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to patient: _____

SECONDARY INSURANCE:

Carrier Name _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to patient: _____

I give my consent to Dermatology Associates that they may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology Associate's Notice of Privacy Practices for a more complete description of such uses and disclosures.

_____ _____
Patient/Legal Guardian's Signature **Date**

Patient Financial Responsibility

I understand and agree to pay for all charges incurred regardless of insurance coverage. I hereby authorize my insurance carrier to pay and assign all medical and/or surgical benefits to Dermatology Associates.

_____ _____
Patient/Legal Guardian's Signature **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM.

I, _____, have received a copy of or was offered a copy of Dermatology Associates Notice of Privacy Practices.

_____ _____
Signature of Patient Date

NAME:_____ **DATE OF BIRTH:**_____

History and Intake Form

Sex: Male or Female

Marital Status: _____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Yes or No (please circle one)

Preferred Language: (circle one)
English
Spanish
Other: _____

Name of Primary Care Doctor _____

Is it ok to leave a detailed message? Yes or No (please circle one)

Is it ok to mail results or reminders to your home address? Yes or No (please circle one)

Emergency Contact Information:
Please list any persons (s) and phone numbers (s) that we may contact reguarding any results, payment, or any healthcare operation.

_____

_____

Pharmacy: Name: _____
Address: _____ Phone Number: _____

_____

We send all biopsies to KWB Pathology in Tallahassee. If your insurance company requires that your biopsy be sent somewhere else, please indicate here: _____

Otherwise, do we have your permission to send your biopsy to KWB Pathology?

Yes or No (please circle one)

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None

Other _____

Past Surgical History: (please circle all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids Hysterectomy: Uterine Cancer
- ☐ None

Other _____

(OVER)

Skin Disease History: (please circle all that apply)

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever / Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ None

Other _____

Flu vaccine this year? YES or NO

Pneumonia vaccine this year? YES or NO

Do you have a family history of Melanoma?

If yes, which relative(s)? _____

Any other family history: _____

Alcohol use: ❑ Does not drink ❑ 2 Drinks a day ❑ More than 3 drinks a day

Smoking History: ❑ Never Smoked ❑ Quit-Former Smoker ❑ Smokes Less Than Daily ❑ Smokes Daily

Medications: (Please enter all current medications including strength, dosage and frequency.)

	Drug Allergies: Circle if none: NONE