Charles R. Kovaleski, MD
Diplomate, American Board of Dermatology
Board-certified Dermatologist

Stephen Plumb, DO
Fellowship-Trained Mohs Surgeon
Fellowship-Trained Dermatopathologist
Board-certified Dermatologist
Board-certified Dermatopathologist
Board-certified Anatomic & Clinical Pathologist

DERMATOLOGY ASSOCIATES
SKIN & CANCER CENTER

(850) 769-SKIN (7546) • Fax (850) 785-2123
1900 Harrison Ave • Panama City, FL 32405

Robert J. Siragusa, MD
Diplomate, American Board of Dermatology
Board-certified Dermatologist

Christopher M. Wolfe, DO, FACMS
Fellowship-Trained Mohs Surgeon
Board-certified Mohs Surgeon
Board-certified Dermatologist

Bret Johnson, MD
Associate, American Board of Dermatology

Charles Byron, MPAS, PA-C • Kelly Wood, MPH, PA • Mary Carmon, APRN
• Jenny Owens, APRN • Adrienne Keely, APRN • Barry Newton, PA-C

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.

_____ _____
X Patient Signature / 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.

_____ _____
X Patient Signature / 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.

_____ _____
X Signature of Patient Date

SEX: Male or Female
Gender Identity: _____

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 on your voice mail? Yes or No (Please Circle One)

Is it ok to mail results or reminders to your home address? Yes or No (Please Circle One)

Occupation: _____

City, State: _____ Place of Birth: _____

Emergency Contact Information: / Concent to release health information to certain individuals.
Please list any person(s) and phone number(s) that we may contact regarding any treatment, payment, or any healthcare operation.

NAME:_____ PHONE: _____ RELATIONSHIP: _____

NAME:_____ PHONE: _____ RELATIONSHIP: _____

Pharmacy: Name: _____

Location: _____

_____

You may have a biopsy performed today during your visit. It is the patient's responsibility to supply the name of the laboratory that your insurance plan covers for these biopsies. Our in-house lab is contracted with most insurance plans, but if your insurance requires that your biopsy be sent elsewhere, please indicate this in the space provided: _____ Otherwise, all biopsies will be sent to Dermatology Associates Lab.

Patient Initial and Date: _____

Please list any medical or surgical history:

- ❑ Arthritis
- ❑ Diabetes
- ❑ Renal disease
- ❑ HIV/AIDS
- ❑ Hepatitis A, B, or C
- ❑ Hypertension
- ❑ Pacemaker
- ❑ Seizures
- ❑ Stroke
- ❑ Heart valve replacement
- ❑ Hip replacement - R / L
- ❑ Knee replacement - R / L
- ❑ Colectomy
- ❑ Mastectomy
- ❑ Mechanical Valve Replacement
- ❑ Heart Transplant
- ❑ Kidney Transplant
- ❑ Basal Cell Carcinoma
- ❑ Squamous Cell Carcinoma
- ❑ Melanoma

Other: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please List any Drug Allergies:_____ NONE

Please circle NONE if no known drug allergies

Have you had the following vaccinations this year?

Flu vaccination? YES or NO (please circle one)
If previously received what date? _____
Pneumonia vaccination? YES or NO
If previously received what date? _____

Smoking history:

- ❑ Never smoked
- ❑ Quit / Former smoker
- ❑ Smokes less than daily
- ❑ Smokes daily

Medication list: Please include name, strength, dosage, and frequency of each medication:

Do we have permission to request your prescription list from the pharmacy? **YES NO** *Please Circle One*

Do you have a family history of melanoma? YES or NO

If so, which relative? _____

If over 65 years of age:
Do you have a Medical Power of Attorney? YES or NO

Whom: _____

Relationship: _____

Phone: _____

Do you have a Living Will? YES or NO
I am unable to respond to these questions ❑
Which statement best reflects your wishes on advanced care recommendations:

- ❑ Do Not Intubate
- ❑ Do Not Resuscitate
- ❑ Full Cardiopulmonary Resuscitation