Advanced Dermatology

**Leavitt Medical Dba Advanced Dermatology**
PO Box 862823
Orlando, FL 32886-2823
(800) 434-4111

## PATIENT INFORMATION

| NAME (Last, First Middle) | | | | | SSN# | BIRTHDATE | SEX |
|---|---|---|---|---|---|---|---|
| LOCAL ADDRESS | | | CITY, STATE ZIP | | SECONDARY/BILLING ADDRESS (if Applicable) | | |
| PRIMARY PHONE | EMAIL ADDRESS | | | | CITY, STATE ZIP | | |
| MARITAL STATUS | STUDENT STATUS ☐ Full-time ☐ Part-time | SMOKER (Y/N)? | VETERAN (Y/N)? | PRIMARY CARE PROVIDER | HOME PHONE | | |

| | |
|---|---|
| PRIMARY EMPLOYER | SECONDARY EMPLOYER (if Applicable) |
| ADDRESS | ADDRESS |
| CITY, STATE ZIP | CITY, STATE ZIP |
| WORK PHONE | WORK PHONE |

## RESPONSIBLE PARTY INFORMATION (if Different than above)

| NAME (Last, First Middle) | | | | | SSN# | BIRTHDATE | SEX |
|---|---|---|---|---|---|---|---|
| LOCAL ADDRESS | | | CITY, STATE ZIP | | SECONDARY/BILLING ADDRESS (if Applicable) | | |
| HOME PHONE | DAY PHONE | EMAIL ADDRESS | | | CITY, STATE ZIP | | |
| MARITAL STATUS | STUDENT STATUS ☐ Full-time ☐ Part-time | SMOKER (Y/N)? | VETERAN (Y/N)? | PRIMARY CARE PROVIDER | HOME PHONE | | |
| RELATIONSHIP TO PATIENT | | | | | | | |

## PRIMARY INSURANCE

| | | | |
|---|---|---|---|
| NAME OF INSURANCE COMPANY | | POLICY# | |
| NAME OF INSURED | | GROUP# | |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT $ | |
| CITY, STATE ZIP | PHONE | DEDUCTIBLE $ | |
| RELATIONSHIP TO PATIENT | | EFFECTIVE DATE | EXPIRATION DATE |

## SECONDARY INSURANCE (if Applicable)

| | | | |
|---|---|---|---|
| NAME OF INSURANCE COMPANY | | POLICY# | |
| NAME OF INSURED | | GROUP# | |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT $ | |
| CITY, STATE ZIP | PHONE | DEDUCTIBLE $ | |
| RELATIONSHIP TO PATIENT | | EFFECTIVE DATE | EXPIRATION DATE |

SIGNATURE OF PATIENT/GUARDIAN ______________________ DATE ______________

PLEASE INITIAL EACH LINE ITEM

**Advanced Dermatology & Cosmetic Surgery**

Informed Patient Consent

______ I give my permission for the Physicians and staff of ***Advanced Dermatology & Cosmetic Surgery*** to treat me as deemed necessary in the exercise of their professional judgment.

______ I understand that ***Advanced Dermatology & Cosmetic Surgery*** employs Advanced Registered Nurse Practitioners [ARNP] and Physician Assistants [PA] and if I am scheduled with them, I agree to see them instead of a physician.

______ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

______ I authorize my doctor to release any information, including 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 and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor or medical group any benefits for services rendered.

______ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

______ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

______ I authorize the physician[s], mid-level providers, aestheticians or staff of ***Advanced Dermatology & Cosmetic Surgery*** to educate me regarding skin care products or devices suitable for my disease state or diagnosis. I understand that I can opt-out from receiving this information at any time by writing to the Privacy Officer, 151 Southhall Lane, Suite 300 , Maitland, FL 32751.

______ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

______________________________ ______________

Patient Name or Legal Guardian/Patient Representative [Print] Date

______________________________ ______________ ______

Signature of patient or patient's legal guardian/representative Witness Date

# **PLEASE INITIAL EACH LINE!**

**EXHIBIT 1**
**Revised January 1, 2017**
**WRITTEN ACKNOWLEDGEMENT FORM**
**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

## ADCS CLINICS, LLC

I, ____________________________, have (1) received a copy of the Notice of the Privacy
Patient Name

Practices or
(2) has been offered a copy of the Notice of the Privacy Practices but declined to accept a copy.

____________________________
Signature of Patient

____________________
Date

OR

**WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A RECEIPT OF NOTICE OF PRIVACY PRACTICES**

On the ___ day of _____________, 2017, the Notice of Privacy Practices was

_____offered and/or given to____________________________.
Patient Name

____ The Patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

____ The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

____________________________
Signature of Employee
that offered the Patient the Notice

____________________
Date

# MEDICAL HISTORY

*The doctors and staff of Advanced Dermatology & Cosmetic Surgery are pleased that you have chosen us for your health care needs. Please complete this form so we may better serve you. The information you provide will assist us in attending to your healthcare needs more effectively and efficiently. It is important that you provide us with any changes or updates (address, insurance company, etc.) each time you see us. For more information about the products and services we offer, please speak with a member of our staff.*

Patient______________________________ Date______________

Reason for today's visit______________________________ Date of Birth: ______________

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 Clot/Phlebitis ☐ Mitrel Valve Prolapse

**Other Systemic**

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

| **Current Medication** | **Y** | **N** | |
|---|---|---|---|
| Do you have any allergies to food or medicine? | ☐ | ☐ | If yes, please list ______ |
| Do you currently use any prophylactic antibiotics? | ☐ | ☐ | If yes, please list ______ |
| Do you currently drink alcohol? | ☐ | ☐ | If yes, what ______ Amt per day: ______ |
| Do you currently use IV drugs? | ☐ | ☐ | If yes, what ______ Amt per day: ______ |
| Do you currently take any medication? | ☐ | ☐ | If yes, please list ______ |
| Have you ever been exposed to HIV/AIDS? | ☐ | ☐ | Have you ever had a blood transfusion? Y ☐ N ☐ |
| Ever had a 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(s) ______ |
| Do you currently use skin care products? | ☐ | ☐ | (If yes, what) ______ |
| When exposed to the 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: ______________

**Please answer the following questions:**

| | Y | N |
|---|---|---|
| A. Do you smoke? | ☐ | ☐ |
| B. Do you bleed easily? | ☐ | ☐ |
| C. (Women) Are you pregnant? | ☐ | ☐ |
| D. Do you have artificial joints, pins or screws? | ☐ | ☐ |
| E. Do you require antibiotics prior to surgery? | ☐ | ☐ |

If no, date of last menstrual period: ______________

F. What is your occupation? ______________

Completed by: Patient ☐ ______________ (initial)
Nurse ☐ ______________ (initial)
M.A. ☐ ______________ (initial)

Signed by Physician: ______________ Date ______
Reviewed by: ______________ Date ______

Preferred Pharmacy: ______________

Location: ______________ Pharmacy Phone Number: ______________

Nurse: ______ (initial) M.A. ☐ ______ (initial) Reviewed by: ______ (initial) Date: ______