PRESTIGE DERMATOLOGY

Dr. Natalie L. Monticciolo
Phone: (727) 263-DERM - Fax: (727) 849-3208

PLEASE FILL OUT COMPLETELY, SIGN WHERE INDICATED, PLEASE PRINT

PATIENT information: Date _____

Name _____ Parent / Guardian Name _____

Address _____ City _____ State _____ Zip _____

Home Ph _____ Work Ph _____ Cell Ph _____ Employer _____

D.O.B. ____/____/_____ Age ____ Sex _____ SS # (required) _____-_____-_____ Occupation _____

Martial Status (circle one) Single Married Divorced

Spouse's Name _____ Occupation _____ Work Phone _____

RESPONSIBLE PARTY: (Insured)

Name _____ D.O.B. ____/____/_____ SS# _____-_____-_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Relationship to Patient _____

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name _____ Home Phone _____

Address _____ Work Phone _____

REFERRAL INFORMATION: (Please check the appropriate box below to help us determine how you were referred to our office)

☐ Physician ☐ Friend ☐ Relative ☐ One of our Patient ☐ Billboard

☐ Advertising ☐ The Yellow Pages ☐ Internet ☐ Insurance ☐ Other

Primary Care Physician _____ Phone _____

FINANCIAL RESPONSIBILITY:

- I understand that all co-payments, deductibles, and past due balances are due at the time of the visit. If I am uninsured, I understand that the payment is due at the time of the visit. I have verified participation of the provider with the insurance company.
- I understand that if my insurance coverage has expired or lapsed, I will be responsible for payment. If my insurance company denies payment or does not pay within 35 days as required by the state law, I am responsible for payment.
- In the case of returned checks, the fee charged by the bank will be added to my account. In the case of nonpayment for services performed, 10% interest will be added to my account from the date of service.
- All collection costs incurred by Prestige Dermatology for outstanding balances will be added to my account. I understand that I am financially responsible for cosmetic, non-covered or medically non-indicated services.
- I hereby authorize the physicians/providers of Prestige Dermatology to provide medical treatment to myself/child. I authorize payment of medical benefits to physician or supplier or supplier for these service and all future claims.

X _____ Date____/____/_____
Signed (Patient or Parent/Guardian)

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PATIENT CONSENT FORM

Our Notice of Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosures of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

This Consent was signed by: _____ Date____/____/____

Patient or Guardian – Printed Name

Relationship to Patient (if other than patient): _____

Witness: _____ Date_____/_____/____

Practice Representative

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

_____

Please list the address and telephone number(s) where you would like any correspondence from our office sent if other than your home.

_____

_____

Patient Name _____ D.O.B._____/_____/_____

Patient / Guardian Signature _____ Date _____/_____/_____

PRESTIGE DERMATOLOGY

History Intake Form

Patient Name: _____ **DOB:** ____/____/_____

Race: _____ **Ethnic Group** _____ **Gender: M F**

Preferred Language _____

Email _____

Preferred Pharmacy _____

Pharmacy Phone _____**Pharmacy City or Zip** _____

Primary Care Physician _____

PLEASE CIRCLE ALL THAT PERTAIN TO YOU: **NONE**

Anemia
Angina
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Blood Transfusion
Bone Marrow Transplant
Breast Cancer
Colon Cancer
Congestive Heart Failure
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Epilepsy
GERD
Hearing Loss
Heart Attack
Hepatitis
High/Low Blood Pressure
HIV/AIDS
High Cholesterol
Leukemia
Liver Disease
Lung Cancer
Lymphoma
Mitral Valve Prolapse
Prostate Cancer
Radiation Treatment
Seizures
Shortness of Breath
Stroke
Tuberculosis

PAST SURGICAL HISTORY: Please circle all that pertain to you **NONE**

Appendix Removed
Bladder Removed
Breast Implant
Breast Reduction
Colectomy: Colon Resection
Colectomy: Diverticulitis
Colectomy: IBD
Coronary Artery Bypass
Gallbladder Removed
Heart Transplant
Hysterectomy
Joint Replacement _____
Kidney Removal
Kidney Stone Removal
Kidney Transplant
Mastectomy
Lumpectomy
Ovarian Cancer
Ovaries Removed
Prostate Cancer
Spleen Removed
Testicles Removal

History Intake Form (Cont. Page 2)

Patient Name: _____ **DOB:** ____/____/_____

SKIN DISEASE HISTORY: **NONE**

Acne
Actinic Keratosis
Asthma
Basal Cell Cancer
Blistering Sunburn
Dry Skin
Eczema

Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Cancer

FAMILY HISTORY OF SKIN CANCER: YES NO
If yes, which and who?
_____
_____
_____

Reason For Today's Visit

Do you currently use sunscreen? Yes No

Does it contain Zinc? Yes No SPF: _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

Do you have any allergies to medications? Yes No

If yes, which allergies:

_____

_____

_____

SOCIAL HISTORY: **NONE**

Cigarette Smoking:
Current Smokes
Former Smoker
Never Smoked

Alcohol Use:
Less than 1 Drink A Day
1-2 Drinks Per Day
3 Or More Drinks Per Day

PRESTIGE DERMATOLOGY

Please complete the following information about ALL medication, include alternative medications and non-prescription medications.

Patient Name: _____ D.OB. ____/_____/_____

Medication Name	*Dose*	*Frequency*	*Prescribing Practitioner*	*Reason for Medication*