O'DONOGHUE DERMATOLOGY

1952 Field Rd Sarasota,FL 34231 *941.926.7546*
www.dermatologyexperts.com

Patient **Legal** Name (First, Middle, Last)	Date of Birth	Age	Sex	Social Security Number **(REQUIRED)**

Primary Address	City	State	Zip	Home Cell Work
Summer Address	**City**	**State**	**Zip**	**Home ( )**

Legal Guardian / Power of Attorney (if minor or applicable)	Marital Status: ☐single ☐married/partnered ☐divorced ☐widowed

Emergency Contact	Relationship	Emergency Contact Number

Uninsured method of payment: ☐Cash ☐Credit (Visa, Amex, Mastercard)

Primary Insurance:		**Secondary Insurance:**	
Subscriber ID:	Insured's Name:	Subscriber ID:	Insured's Name:
Relationship to patient:	Date of Birth:	Relationship to patient:	Date of Birth:

Employer:	**Name of Referring Physician**: Phone:

Name of Primary Care Physician:
Phone: Fax:

How did you hear about our office? ☐**Doctor**_____ ☐**Patient**_____
(Please check all that apply)
☐Internet ☐Phone Book ☐Newspaper ☐Magazine ☐Staff ☐Other:_____

☐Yes, I would like to receive occasional O'Donoghue Dermatology news and service/product updates.
(We do not sell, share, rent, or disclose your information. By checking the box, you give us permission to add you to our mailing list.)

EMAIL Address:

I Certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to O'Donoghue Dermatology.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, co-insurances and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of service provided.

Payment is required for all services at the time they are rendered. **All applicable co-payments and deductibles will be collected at the time of service.** Our terms are net 30 days. Appointments that are cancelled 24 hours prior to the appointment time or not attended may be charged a $75 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature: Date:

I, the undersigned, hereby consent to medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. Some risks/side effects include: pain-during and after the procedure, bleeding, infection, light-headed/fainting, scars (possible disfiguring), hyperpigmentation, hypopigmentation, recurrence (re-growth) of the lesion being treated, and nerve injury with loss of nerve or muscle function.

I understand that any pathology and/or laboratory fees that are billed independently of O'Donoghue Dermatology are ultimately the patient's responsibility.

Patient Signature: Date:

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ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practice provides information about how we may use and disclose your protected health information (PHI). It discusses your rights as a patient and O'Donoghue Dermatology's duties with respect to your PHI. 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.

_____ _____

Print name ***Date of Birth***

_____ _____

Signature of Patient or Legal Representative ***Today's Date***

CONFIDENTIAL COMMUNICATIONS REQUEST FORM

We highly value your right to privacy. Please be aware that it is our policy to call both your home phone and cell phone numbers in order to:

- Confirm appointments
- Leave medical instructions and information
- Leave messages containing laboratory and biopsy results
- Return your calls
- Postcard reminders

I prefer you to share information with the following:

Name	**Phone #**
_____	_____
_____	_____
_____	_____

Please indicate any special restrictions you would like to follow, below: *(Initial all that apply)*

_____ **DO NOT** leave messages on my home answering machine.

_____ **DO NOT** leave a message with a family member/friend at my home telephone number.

_____ **DO NOT** leave a message with my employer to return a call to this office.

_____ **DO NOT** call my cell phone and disclose information on voicemail.

_____ **DO NOT** disclose any/all information (except where prohibited by law) to the following Person(s): _____.

_____ **OTHER** (please specify): _____

I may revoke or change this authorization at any time by completing another form. Please refer to the complete Privacy Notice available upon request.

_____ _____

Signature of Patient or Legal Representative **Date**

History and Intake Form

Name:_____ Date of Birth:_____

Past Medical History: (please list current and past medical problems)

_____

_____

Past Surgical History:

_____

_____

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 _____

Do you wear Sunscreen? Yes ☐ No ☐
If yes, what 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)? _____

Medications: (Please enter all current medications and their dose and frequency)

_____

_____

Immunizations: (check if you have had) Influenza:☐ Pneumonia:☐

Drug Allergies: (Please enter all allergies and your reactions)

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smoker: Y ☐ N ☐ ow many packs per day: ___
Former Smoker Y ☐ N ☐ w Many Years: ____
Never Smoker

Alcohol Use:

How many times have you had more than 5 drinks in one day this past year? _____

(Continues on back side)

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Rash	☐	☐
Problems with Healing	☐	☐
Problems with Bleeding	☐	☐
Problems with Scarring	☐	☐
Fever or Chills	☐	☐
Immunosuppression	☐	☐

ALERTS: (please circle all that apply)
Allergy to Adhesive ☐
Allergy to lidocaine ☐
Allergy to topical antibiotics ☐
Artificial heart valve ☐
Artificial joint replacement ☐
Blood thinners ☐
Defibrillator ☐
MRSA ☐
Pacemaker ☐
Require antibiotics prior to a surgical procedure ☐
Rapid heart beat with epinephrine ☐
Are you pregnant or currently trying to get pregnant? ☐
History of Malignant Melanoma ☐

Advanced Care Planning (circle one): y ☐ / n ☐

Do you have a living will (circle one): ☐ / ☐

Pharmacy Information: (required)

Preferred pharmacy Name and Location:

_____

Pharmacy Phone#: _____

City and Zip code:_____