SelectSkinMD
DERMATOLOGY | SKIN CANCER SPECIALISTS

1600 36th Street, Suite B
Vero Beach, FL 32960
Phone: (772) 567-1164

Ver. 03-2019

Date: _____

LEGAL Name: _____ Soc. Sec# _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Email Address: _____

Spouse or Parent / Guardian: _____

Mailing Address: _____ City / State: _____ Zip: _____

Seasonal Address: _____ City / State: _____ Zip: _____

Home Phone: _____ Cell: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Employer: _____ Employer Phone: _____

Friend or relative <u>not living with you</u> that we may contact in case of emergency (REQUIRED):

Name: _____ Telephone: _____

Referring Physician: _____ City: _____ State: _____

Primary Physician: _____ City: _____ State: _____

Preferred Pharmacy

Name: _____ Street / City: _____

WE WILL NEED TO COPY ALL OF YOUR CURRENT INSURANCE CARDS FOR OUR RECORDS

<u>Policy Holder's Insurance Information is REQUIRED to file to Insurance</u>

Primary Insurance Company

Insurance Company Name: _____ ID: _____

Name: _____ Date of Birth: _____ Soc. Sec #: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

Secondary Insurance Company

Insurance Co Name: _____ ID #: _____

Name: _____ Date of Birth: _____ Soc. Sec #: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

Past Medical History

Patient Name: _____

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____

_____

Patient Name: _____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have 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?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____

_____

Medications

Patient Name: _____

List all current medications:

_____

_____

_____

- ☐ I allow SelectSkinMD to access my prescription medication history from healthcare providers or pharmacies for treatment purposes.
- ☐ I will **not** allow SelectSkinMD to access my prescription medication history allowing them to prescribe appropriately.

Allergies

List all allergies and reactions if known:

_____

_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Primary Physician:_____

Pharmacy:_____

Patient Name: _____

Occupation and Workplace:

_____

Place of Residence:

_____

_____

Family History

Please include only first-degree relatives:

_____

_____

Review of Systems

Do you have any of the following?

- ☐ Problems with Bleeding
- ☐ Problems with Healing
- ☐ Problems with Scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Allergy to Topical Antibiotic Ointment
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Sore Throat
- ☐ MRSA
- ☐ Blurry Vision
- ☐ Abdominal Pain
- ☐ Thyroid Problems
- ☐ Bloody Stool
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression
- ☐ Changing Mole
- ☐ Blood Thinners

Alerts

Do you have any of the following?

- ☐ Allergic to Adhesive
- ☐ Allergic to Lidocaine
- ☐ Artificial Heart Valve
- ☐ Artificial Joints within the past two years
- ☐ Premedication Prior to Procedures

PATIENT PRIVACY QUESTIONAIRE

HIPAA ACKNOWLEDGEMENT

PRESCRIPTION MEDICATION REQUEST CONSENT

Name: _____ Date: _____

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health-related matters.

Please list any preferred phone numbers:

Home: _____ Cell: _____

Work: _____ Other: _____

Can we leave a message at the above numbers? ___ Yes ___ No

Are there any restrictions with regard to our office contacting you with medical information?

_____

_____

Would you like to authorize an individual(s) as your personal representative? This person would have the authority to schedule, confirm or change appointments only. ___ Yes ___ No ___ N/A If yes, please list full names:

_____ _____

I agree that my prescription medication history may be requested from other healthcare providers or third party pharmacy benefit payors and used for treatment purposes.

_____ _____

Patient or Personal Representative Signature Date

SelectSKinMD has offered me a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

_____ _____

Patient or Personal Representative Signature Date

SelectSkinMD
160036th Street, Suite B
Vero Beach, FL 32960

SIGNATURE ON FILE

Medicare Beneficiaries

LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurances.

Print Patient's Name **HIC (Medicare#)**

Patient's Signature **Date**

FINANCIAL POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to contact our billing office with any questions regarding filing of insurance and your financial obligation to Dr. Srivastava. Please be advised that this is not an all-inclusive list.

Please initial by each paragraph below indicating that you have read and agree to each.

***Initial*_____** If we participate with your insurance, we are contractually obligated to collect any deductible, coinsurance and / or co-pay at the time of service.

***Initial*_____** Dr. Srivastava is a participating provider for MEDICARE, CIGNA, BLUE CROSS/BLUE SHIELD (except HMO), AVMED, WellMed, and some United Healthcare contracts – patient to inquire prior to their visit. If you have insurance coverage that is not one with which we are a provider, we will file your insurance **once** as a courtesy, however, if they do not pay within 30 days, any balance due will be your responsibility. **If you have a co-pay stated on your insurance card, we will collect that at the time of your visit.**

***Initial*_____** I authorize release of information concerning healthcare, advice, treatment to my insurance company(s), other physicians' offices where I am a patient, a physician's office that I am being referred to or to a surgical facility in preparation for surgery.

***Initial*_____** I understand that it is my responsibility to notify the office if my medical or medication information changes.

I, the undersigned, authorize payment of medical benefits for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I agree to be responsible for any legal fees and / or court costs incurred as a result of my failure to pay for services rendered.

Please print Patient's Name: _____ Date: _____

Patient's or Parent/Guardian signature:_____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Srivastava for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine if these benefits are payable for related services. The Medicare provider, Dr. Monika Srivastava agrees to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed:_____ Date: _____