ADVANTAGE DERMATOLOGY, P.A.

PATIENT DEMOGRPAHIC INFORMATION (Please Print)

LAST NAME	FIRST NAME		MIDDLE INITIAL
Street Address	**City**	**State**	**Zipcode**

Home Phone	Cell Phone	Work Phone (If applicable)

Date of Birth (MM/DD/YYYY)	Gender (Select)	Social Security Number
	_____ Male _____ Female	

Marital Status (Select)	Occupation/Industry	Employment Status (Select)
_____M _____S _____D _____W _____SEP		_____Working _____Retired _____Student _____Unemployed _____Military

Race	Ethnic Group	Preferred Langauge	Do you require a translator?
_____ Asian _____ American Indian _____ White _____ Black or African American _____ Other Race _____ Native Hawaiian/Pacific Islander	_____ Hispanic or Latino _____ Non-Hispanic or Latino	_____ English _____ Spanish _____ Other	_____Yes _____No **Which language?**

How did you hear about our practice?

_____Event _____Health Fair _____Friend/Relative _____TV Commercial _____Radio _____Website _____Social Media
_____Other:_____ _____ Referral from Doctor: _____

Primary Care Provider/Referring Provider

Name	
Practice Address	
Phone	**Fax**

Appointment Reminders & Patient Portal

How would you like to receive appointment reminders?	_____ Automated Reminder to Home Phone _____Text Reminder to Cell Phone
Email Address:	
***Patient Portal-Medical Records**	You will receive an email invitation to your online patient portal. You may log in to the portal at anytime to review and download your medical records, update your pharmacy, and confirm your current medications. The portal allows you to remain actively involved in your healthcare and saves time, paper, and money. You may also communicate with your provider team through secure messaging within the patient portal.
***Payment Portal-Online Bill Pay**	You will receive an email invation to pay your bills online. This is a quick and cost efficient method of staying current with your medical expenses.
***Office Promotions**	You will receive an email about upcoming promotions in our office. You can opt out of receiving these emails and any future emails at anytime with a single click.

Whom do you authorize us to speak with regarding your medical care in person and/or over the phone?

1. Name	Phone	Relationship
2. Name	**Phone**	**Relationship**
3. Name	**Phone**	**Relationship**

Healthcare Decision Maker

1. Have you designated someone to make healthcare decisions on your behalf?	_____Yes _____No
2. If yes, what is the name of that person?	
3. If yes, write the name of the document identifying that individual as your durable power of attorney or healthcare surrogate and provide a copy to our office for storage in your medical record.	_____

Patient Signature and Date

Patient Signature:	Date Completed:

ADVANTAGE DERMATOLOGY, P.A.

PRIMARY INSURANCE (The policyholder is the person who applied for insurance coverage.)	
Insurance Company Name: *(Example: Florida Blue)*	
Insurance Plan Name: *(Example: BlueSelect)*	
Plan Type:	**_____ Medicare _____ PPO _____ HMO _____ POS _____ EPO _____ Indemnity**
Member ID: *(Example: XYZ123456789)*	
Policyholder's Name on the Card:	
Policyholder's DOB:	
Policyholder's SSN#:	
Relationship of Patient to Policyholder:	**_____SELF _____SPOUSE _____CHILD _____OTHER _____**
Does your insurance plan require a referral from your primary care provider before you are able to see a specialist provider (ex: dermatologist)?	**_____ Yes _____ No** ***If Yes, please reach out to your primary care provider to obtain the referral. It can be faxed to Advantage Dermatology, P.A.'s Referral Fax Line: 904-257-5005**

SECONDARY INSURANCE (The policyholder is the person who applied for insurance coverage.)	
Insurance Company Name: *(Example: Florida Blue)*	
Insurance Plan Name: *(Example: BlueSelect)*	
Plan Type:	**_____ Medicare _____ PPO _____ HMO _____ POS _____ EPO _____ Indemnity**
Member ID: *(Example: XYZ123456789)*	
Policyholder's Name on the Card:	
Policyholder's DOB:	
Policyholder's SSN#:	
Relationship of Patient to Policyholder:	**_____SELF _____SPOUSE _____CHILD _____OTHER _____**
Does your insurance plan require a referral from your primary care provider before you are able to see a specialist provider (ex: dermatologist)?	**_____ Yes _____ No** ***If Yes, please reach out to your primary care provider to obtain the referral. It can be faxed to Advantage Dermatology, P.A.'s Referral Fax Line: 904-257-5005**

Advantage Dermatology, P.A.
1514 Nira Street • Jacksonville, Florida 32207 • Phone: 904-387-4991 • Fax: 904-384-3613

Financial Policy

It is the policy of Advantage Dermatology, P.A. to provide our patients with access to the highest quality dermatological care available. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

PAYMENT AT TIME SERVICE

We will bill your insurance for all services; however, we require that you pay any portion of your costs not covered by your insurance due to deductibles, co-insurances or co-payments on the day of service. Billing for these items is not only costly, but our statements often go unpaid. This results in increased costs to all patients.

PREPAID COSMETIC SERVICES

Prepaid cosmetic services are non-refundable.

SUBMISSION OF CLAIMS

Your health insurance plan is a contract between you and your insurer. Charges not paid by your insurance company are your responsibility, as a courtesy we file claims to the insurer. We can work together to resolve most insurance issues in a mutually acceptable manner. The patient is responsible for understanding his or her policy limitations. In the event your health insurance determines that a service you have received is not covered, you will be responsible for payment.

OUTSTANDING BALANCES

We urge you to keep your account current. When an account balance becomes more than 90 days past due, it will be referred to collections. Any additional fees incurred on the account will be the responsibility of the patient. If you need to make special payment arrangements, it is your responsibility to contact one of our billing managers before your account is sent to collections. Patients who fail to make payments could be discharged from the practice.

PAYMENT OPTIONS

You will receive monthly statements. The amount showing in the "Please Pay" section is your financial obligation. It is due and payable upon receipt. For your convenience, we accept payment in the form of cash, check, Visa, MasterCard, American Express and Discover. Payments may be called in at (904) 387-4991, or mailed to PO Box 743232, Atlanta, GA 30374-3232.

RETURN CHECK, NSF, CLOSED ACCOUNTS

Payments made to Advantage Dermatology, P.A. that are not honored by the bank will incur a return check fee of $50.00. Failure to submit new payment with the fee included within 15 days of receiving the return check notice from Advantage Dermatology, P.A. could result in the account being turned over to the State Attorney's office. All future payments will need to be made in the form of credit card, money order or cash.

NO-SHOW FEE

Appointments cancelled without 48 hours' notice will be assessed a no-show fee.

- $50.00-Clinical
- $50.00-Cosmetic
- $100.00-Surgery

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Financial Responsibility

I understand that I am financially responsible for all services rendered. I understand that it is my responsibility to confirm my insurance coverage with my insurance carrier ***prior*** to my visit. I understand that I am responsible for all applicable copayment, coinsurance, deductible, and payment for non-covered services. I have been offered a copy of Advantage Dermatology, P.A.'s Financial Policy.

I understand that if I am covered by an insurance carrier that requires a referral or authorization from my primary care physician or insurance carrier, it is my responsibility to obtain that referral/authorization prior to my visit. If my insurance carrier requires direct contact with Advantage Dermatology, P.A. to authorize a referral/authorization, I will inform Advantage Dermatology, PA of this requirement ***prior*** to my visit.

I understand that I will be charged a no-show fee for appointments cancelled without 48 hours' notice. The no-show fee is $50.00 for clinical appointments, $50.00 for cosmetic appointments, and $100.00 for surgical appointments. I understand that prepaid cosmetic services are non-refundable.

Assignment of Insurance Benefits & Payment Responsibility

I permit the named insurance carrier(s) to provide payment of my insurance benefits, if any, directly to Advantage Dermatology, P.A. for services rendered by Advantage Dermatology, P.A. to me during the course of my examination and treatment. I understand that I am responsible for payment for all non-covered services.

Information Release

I authorize Advantage Dermatology, P.A. to release my insurance carrier or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to the related service(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Advantage Dermatology, P.A. Regulations pertaining to Medicare assignment of benefits also apply.

Medicare and Medicaid Participation

Our practice is a participating provider of the ***Medicare*** program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance. We do file secondary/supplemental carriers. However, in the event that the secondary carrier does not pay within (sixty) 60 days, patients will be billed the balance.

Advantage Dermatology, P.A. is ***not*** a Florida ***Medicaid*** provider. I understand that claims will ***not*** be submitted to Medicaid. I also understand that I will be responsible for all charges that otherwise would be covered by Medicaid, if Advantage Dermatology, P.A. was a Florida Medicaid provider.

Notice of Privacy Practices

I have been provided a copy of Advantage Dermatology, P.A.'s Notice of Privacy Practices. I understand that I may print an additional copy at any time and that this Notice is available on the practice's website.

My signature below indicates my understanding and agreement to the above statements.

Signature: X _____ **Date:** _____

By parent or guardian if patient is a minor

MEDICAL HISTORY

MEDICAL HISTORY (Please check all that apply)

_____Anxiety

_____Arthritis

_____Asthma

_____Atrial Fibrillation

_____Bone Marrow Transplantation

_____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: _____

SURGICAL HISTORY (Please check all that apply)

_____Appendix Removed

_____Bladder Removed

_____Breast Biopsy (Right, Left, Bilateral)

_____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 Removed

_____Heart: Biological Valve Replacement

_____Heart: Coronary Artery Bypass

_____Heart: Heart Transplant

_____Heart: Mechanical Valve Replacement

_____Heart: PTCA

_____Joint Replacement, Hip (Right, Left, Bilateral)

_____Joint Replacement, Knee (Right, Left, Bilateral)

_____Kidney Biopsy (Nephrectomy)

_____Kidney Stone Removal

_____Kidney Transplant

_____Kidney Nephrectomy (Right, Left)

_____Liver: Hepatectomy

_____Liver: Transplant

_____Liver: Shunt

_____Ovaries Removed: Endometriosis

_____Ovaries Removed: Ovarian Cancer

_____Ovaries Removed: Ovarian Cyst

_____Ovaries: Tubal Ligation

_____Pancreas: Pancreatectomy

_____Prostate Removed: Prostate Biopsy

_____Prostate Removed: Prostate Cancer

_____Prostate Removed: TURP

_____Rectum: APR

_____Rectum: Low Anterior Resection

_____Skin: Basal Cell Carcinoma

_____Skin: Skin Biopsy

_____Skin: Squamous Cell Carcinoma

_____Spleen (Splenectomy)

_____Testicles (Orchiectomy) (Right, Left, Bilateral)

_____Uterus (Hysterectomy): Fibroids

_____Uterus (Hysterectomy): Uterine Cancer

_____Uterus (Hysterectomy): Cervical Cancer

_____NONE

Other: _____

SKIN DISEASE HISTORY

SKIN DISEASE HISTORY

(Please check all that apply to you.)

_____Acne	_____Dry Skin	_____Poison Ivy
_____Actinic Keratoses	_____Eczema	_____Precancerous Moles
_____Asthma	_____Flaking or Itchy Scalp	_____Psoriasis
_____Basal Cell Skin Cancer	_____Hay Fever/Allergies	_____Squamous Cell Skin Cancer
_____Blistering Sunburns	_____Melanoma	_____NONE

Other: _____

_____

_____

_____

Do you wear sunscreen? _____Yes _____No **If yes, what SPF? _____**

Do you tan in a tanning salon? _____Yes _____No

When was your last full skin check? _____

FAMILY HISTORY OF MELANOMA

Do you have a family history of Melanoma? _____Yes _____No

If yes, which relative(s): _____

_____

_____

MEDICATION/PHARMACY/ALLERGY INFORMATION

MEDICATION

(Please list all medications you are currently taking.)

	Medication	**Strength**	**Route (ex. Oral)**	**Frequency**
1				
2				
3				
4				
5				
6				
7				

PHARMACY

(Please list the name and contact information for your pharmacy.)

	Pharmacy	**Address**	**Phone**	**Fax**
1				

ALLERGIES

(Please enter all allergies)

	Allergy	**Reaction**	**Severity** (Mild, Moderate, Severe, Fatal)
1			
2			
3			
4			
5			
6			

SOCIAL HISTORY

SMOKING HISTORY

(Please select all that apply to you)

Smoking Status:

_____Unspecified

_____Never Smoker

_____Former Smoker

_____Current Smoker (Tobacco)

_____Current Smoker (Cigarette)

Date Started Smoking: _____ **Date Quit Smoking: _____**

Number of Packs Per Day: _____ **Total Years Smoking: _____**

Additional Details: _____

ALCOHOL USE, DRUG USE, SEXUAL ACTIVITY, SAFETY

(Please select all that apply to you)

Alcohol Use

_____Alcohol-None

_____Alcohol: Less than 1 drink per day

_____Alcohol: 1-2 drinks per day

_____Alcohol: 3 or more drinks per day

Drug Use

_____Drug Use

_____IV Drug Use

Safety

_____Patient feels safe at home

_____Patient does ***not*** feel safe at home

Sexual Activity

_____Not sexually active

_____Sexually active with one partner

_____Sexually active with more than one partner

_____Same sex partner

Other: _____

SOCIAL HISTORY

DRIVING, EXERCISE, CAFFEINE

Driving Status:

_____Drives in Daytime _____Drives at Night Notes: _____

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

OCCUPATION, WORKPLACE, PLACE OF RESIDENCE

Occupation: _____

Workplace: _____

Place of Residence *(e.g. Home, Apartment, Town House, Dormitory, Condominium):*

_____

FAMILY HISTORY

FAMILY HISTORY

Please list pertinent family history of illness, disease, or cause of death for first degree relatives.
(e.g. mother, father, sister, brother, daughter, son, uncle, aunt, nephew, niece, grandmother, grandfather, grandson, granddaughter, none)

Family Member	**ILLNESS/DISEASE/CAUSE OF DEATH**
Mother	
Father	
_____Sister _____Brother	
_____Daughter _____Son	
_____Aunt _____Uncle	
_____Niece _____Nephew	
_____Grandmother _____Grandfather	
_____Granddaughter _____Grandson	
Other	
None	

SKIN CARE ROUTINE

1. **What *type(s)* of products do you use in your skin care routine?**

Product	Yes/No	Brand
Sunscreen and SPF		
Deodorant		
Body Lotion		
Body Wash		
Face Wash		
Face Lotion/Moisturizer		
Anti-Aging Products		
Toner		
Makeup Remover		
Shaving Product		
Laundry Detergent		
Lip Balm/Chapstick		
Other		

2. **Have you had any cosmetic services in the past? (e.g. Chemical Peel, Microdermabrasion, Laser, Photo Facial, Botox, Juvederm, Latisse etc.)**

   _____

   _____

   _____

3. **We offer periodic promotional events and discounts for cosmetic products and services. Would you like to receive a text or email from our practice regarding these events? You may opt out at any time.**

   ____ No thank you.

   ____ Yes, please text me on my cell phone.

   ____ Yes, please email me.