Skin and Cancer Associates/Center for Cosmetic Enhancement ®

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Date of Birth: / /	Age:	Sex: ❑ M ❑ F	Social Security No.:	Driver's License No. & State:

Home Phone No.: ( )	Work Phone No.: ( )	Cell Phone No.: ( )	Email Address:

Local Street Address:	City:	State:	ZIP Code:
Permanent Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:

Name of Patient (for minor patient):	Name of Parent Employer:	Parent Work Phone No.: ( )

Parent Address (if different):		City:	State:	ZIP Code:

Referred to practice by:	❑ Dr.	❑ Insurance Plan	❑ Yellow Pages
❑ Family/Friend		❑ Website:	❑ Other:

INSURANCE INFORMATION

Person responsible for the bill:	Birth Date: / /	Address (if different):	Home Phone No.: ( )

Occupation:	Employer:	Employer Address:	Employer Phone No.: ( )
Primary Insurance:		Address:	Phone No.:

Insured's Name:	Insured's S.S. No.:	Birth Date: / /	Sex:	Group No.:	Policy No.:

Patient's relationship to subscriber:	❑ Self	❑ Spouce	❑ Child	❑ Other

Secondary Insurance (if any):	Address:	Phone No.: ( )

Insured's Name:	Insured's S.S. No.:	Birth Date: / /	Sex:	Group No.:	Policy No.:

Secondary Insurance (if any):	Address:	Phone No.: ( )

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

AUTHORIZED TO PAY / FOR MEDICARE LIFETIME AUTHORIZATION

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best to my knowledge. I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administrations or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient Signature Date

Other signature if patient is unable to sign Date

History and Intake Form

Name: _____ **Date:** _____

Primary Provider Name: _____

Preferred language: _____

Race:

- ☐ White
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific island islander
- ☐ Other Race

Ethnic Group:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Preferred Pharmacy: _____

_____

Past 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 _____

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA (angioplasty)
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP - Prostatectomy
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery

- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Other
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

_____

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Other _____
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None

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) _

☐ None

_____

_____

_____

_____

Allergies: (Please enter all allergies)

☐ None

_____

_____

_____

Social History: (Please check all that apply)

☐ Not sexually active
☐ Sexually active with one partner
☐ Sexually active with more than one partner
☐ Same gender sex partner
☐ Drug use
☐ IV Drug use
☐ Other _____

☐ Alcohol consumption: None
☐ Alcohol consumption: Less than 1 drink per day
☐ Alcohol consumption: 1-2 drinks per day
☐ Alcohol consumption: 3 or more drinks per day
☐ None

Occupation: _____

Smoking Status: (Please check all that apply)

☐ **Current every day smoker**
☐ **Current some day smoker**
☐ **Former smoker**

☐ **Never smoked**
☐ **Smoker current status unknown**
☐ **Unknown if ever smoked**

Cautions / Alerts: (Please check all that apply)

☐ Allergy to adhesive: rash
☐ Allergy to Lidocaine: itching
☐ Allergy to Lidocaine: palpitations
☐ Allergy to Lidocaine: sweating
☐ Allergy to topical antibiotic ointments
☐ Artificial heart valve

☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Patient vasovagal
☐ Personal history of malignant melanoma
☐ Premedication prior to procedures

- [ ] Artificial joints within past two years
- [ ] Blood thinners
- [ ] Rapid heartbeat with epinephrine
- [ ] Pregnancy or planning a pregnancy

Review of Systems: Are you currently experiencing any of the following? (Please check all that apply)

- [ ] New hair growth on face, chest or abdomen
- [ ] New Moles
- [ ] Problems with bleeding/easy bruising
- [ ] Problems with healing
- [ ] Problems with scarring (hypertrophic or keloid)
- [ ] Rash
- [ ] Sensitivity to sunlight
- [ ] Significant change in existing moles
- [ ] Significant hair loss
- [ ] Significant persistent or intermittent burning of the skin
- [ ] Night sweats
- [ ] Unintentional weight loss
- [ ] Thyroid problems
- [ ] Blurry vision
- [ ] Sore throat
- [ ] Abdominal pain
- [ ] Bloody stool
- [ ] Bloody urine
- [ ] Joint aches
- [ ] Muscle weakness

- [ ] Significant persistent or intermittent itching of the skin
- [ ] Currently having menstrual periods
- [ ] Irregular menstrual cycle
- [ ] Hay fever
- [ ] Immunosuppression
- [ ] Chest Pain
- [ ] Palpitations, irregular heart beat
- [ ] Fever or chills
- [ ] Neck stiffness
- [ ] Headaches
- [ ] Seizures
- [ ] Cough
- [ ] Shortness of breath
- [ ] Wheezing
- [ ] Anxiety
- [ ] Depression

RENDONCENTER
DERMATOLOGY & AESTHETIC MEDICINE

Marta I. Rendon, M.D.
Chere R. Lucas, M.D.
Diplomates American Board of Dermatology
Skin and Cancer Associates

How would you like us to contact you?

Patient's rights of disclosure: In general, the HIPPA privacy rule gives individuals the right to request restrictions on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information made by alternative means.

Please check off the appropriate mode of communication for your detailed medical information, and circle which mode is the best way to reach you.

I _____ (patient's first and last name) wish to be contacted in the following manner:

(Please circle preferential method of contact)

- **HOME Telephone #** _____
  - _____ OK to leave a detailed message
  - _____ Leave message with call back number only
- **CELL PHONE Telephone #** _____
  - _____ OK to leave a detailed message
  - _____ Leave message with call back number only
- **WORK Telephone #** _____
  - _____ OK to leave a detailed message
  - _____ Leave message with call back number only
- **WRITTEN COMMUNICATION**
  - _____ OK to mail home
  - _____ OK to fax to home FAX #_____
  - _____ OK to fax to work FAX #_____

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak to regarding your medical information.

NAME	**RELATIONSHIP**

_____ _____

Patient Signature *Date*

1001 NW 13 st, Suite 100, Boca Raton, FL 33486. (561) 750-0544

SKIN AND CANCER ASSOCIATES

Insurance Assignment Agreement/Privacy Notice Acknowledgment

****PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE****

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____

_____, and assign directly to Skin and Cancer Associates (SCA) all
Name of Insurance Company(ies)

insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that I am responsible for my health insurance deductibles and coinsurance.**

_____ _____ _____
Beneficiary/Patient Signature Relationship Date

MEDICARE and/or MEDICAID

Lifetime Authorization. Medicare and Medicaid patient certification. Patient certification authorization to release information and payment request.

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 me 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 coinsurance.**

_____ _____ _____
Patient Signature Print Patient Name Date

MEDIGAP

NOTE: IF YOU SIGN HERE YOU SHOULD ALSO SIGN FOR MEDICARE ABOVE.

Beneficiary Signature Authorization.

I request that payment of authorized Medigap benefits be made on my behalf to SCA for services furnished to me by the physician(s) of SCA. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Beneficiary/Patient Signature Print Beneficiary/Patient Name

_____ _____
HIC (Medicare) Number Medigap Number

_____ _____
Name of Medigap Insurance Company Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____ _____
Patient Signature Print Patient Name Date

_____
Parent or Authorized representative (if applicable)

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our registration form in full before seeing the doctor.

Payment is due at the time of service. We accept cash, checks, and credit cards. If needed, a payment plan can be established with prior credit approval.

If you have insurance
which will pay our doctor directly, and which we can verify, we still require that you pay all co-payments, deductibles, co-insurance and charges for non-covered services at the time of service.

If you are a member of an HMO or PPO that requires a referral form from your primary care physician, you are responsible to bring this form with you for your visit.

If you have questions or concerns about your bill, you may speak with the:

Patient Accounts Office (305) 623-8025
OR
Outside of Dade (888) 479-6415

Missed appointments- If you are unable to keep an appointment kindly give 24 hours notice. Please, help us serve you better by keeping scheduled appointments.

Important Information About Biopsies

Dermatologists traditionally take a sample (surgical biopsy) of suspicious skin growths or rashes in order that microscopic examination of the sample can be performed, and a diagnosis made.

This is to inform you that the work associated with processing each biopsy, preparing slides, microscopically examining the slide, and issuing a report of the resulting diagnosis (together known as surgical pathology) is a distinct and separate service from the biopsy itself, and there will be a separate charge.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to his Financial Policy.

_____ _____
Signature of responsible party Date

_____ _____
Witness Date