

PLEASE READ AND SIGN

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient signature: _____

Date: ____/____/____

Payment is required for all services at the time they are rendered unless you are in a pre-paid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a \$10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient signature: _____

Date: ____/____/____

**Please present your INSURANCE CARD(s) and a PHOTO ID to the receptionist along with this completed form.
Thank you.**

HIPAA

Patient Consent Form

Our Notice of Privacy 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 disclosure of protected health information about you for 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 Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Acknowledgement of Notice of Privacy Practices

My signature below verifies that I, _____, have received
(Print Name)

a copy of the Notice of Privacy Practices from Romagosa Dermatology Group, LLC

Signature of Recipient _____ Date: ____/____/____

Protected Health Information Authorization

My signature below indicates that I DO / DO NOT (please check one) authorize Romagosa Dermatology Group, LLC to discuss my PHI with my spouse or personal representative.

If yes, please provide their name and phone number.

Name: _____ Phone #: _____ - _____ - _____

Relationship : _____

Signature of Patient _____ Date: ____/____/____

Romagosa Dermatology Group, LLC
Medical History and Intake Form

Patient Name: _____ **D.O.B.** _____

Past Medical History: (Please circle all that apply)

Anxiety	Arthritis	Asthma
Atrial Fibrillation	Bone Marrow Transplantation	BPH
Breast Cancer	Colon Cancer	COPD
Coronary Artery Disease	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

Past Surgical History: (please circle all that apply)

Appendix (Appendectomy)	Bladder: Cystectomy
Breast: Breast Biopsy	Breast: Lumpectomy (both)
Breast: Lumpectomy (left)	Breast: Lumpectomy (right)
Breast: Mastectomy: (both)	Breast: Mastectomy (left)
Breast: Mastectomy: (right)	Colon: Colon Cancer Resection
Colon: Diverticulitis	Colon: IBD
Colon: Colostomy	Gallbladder Removed
Heart: Biological Valve Replacement	Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant	Heart: Mechanical valve Replacement
Joint Replacement: Hip (both)	Joint Replacement: Hip (left)
Joint Replacement: Hip (right)	Joint Replacement: Knee (both)
Joint Replacement: Knee (left)	Joint Replacement: Knee (right)
Kidney: Kidney Biopsy	Kidney: Kidney Stone Removal
Kidney: Kidney transplant	Kidney: Nephrectomy
Liver: Hepatectomy	Liver: Liver Transplant
Liver: Liver Shunt	Ovaries: Endometriosis
Ovaries: Ovarian Cancer	Ovaries: Tubal Ligation
Pancrease: Pancreatectomy	Prostate: Prostate Biopsy
Prostate: Prostate Cancer	Prostate: TURP
Rectum: APR	Spleen: Splenectomy
Testicles: Orchiectomy	Uterus: Hysterectomy (fibroids)
Uterus: Hysterectomy (Uterine Cancer)	Uterus: Hysterectomy(Cervical Cancer)

None

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

Continued on Back

Do you wear sunscreen? Yes No
If yes, what SPF? _____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: (Please list all **CURRENT** medications)

Allergies: (MEDICATION ALLERGIES ONLY)

Social History: (Please circle)

Currently Smokes Never Smoked Former Smoker

Preferred Language: _____

Race: _____ **Ethnic Group:** _____

Preferred pharmacy Name: _____ **Pharmacy Phone #:** _____

Pharmacy City or Zip code: _____

ALERTS: (please circle all that apply)

- Allergy to Adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement within 2 years
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a surgical procedure
- Rapid heartbeat with epinephrine
- Pregnant or currently trying to get pregnant
- Hepatitis
- Latex