Juan Rosario, MD
Ashley East, PA-C
Erin Harris, PA-C

FIRST COAST DERMATOLOGY
Serving the First Coast since 1979

4479 Baymeadows Road
Jacksonville, Florida 32217
904-731-8300 fax 904-737-7901
www.firstcoastdermatology.com

PATIENT INFORMATION

Prefix: Mr. Mrs. Miss Ms. Dr.

Name _____ Date of Birth _____

Age _____ Sex _____ SS# _____ Marital Status _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Mobile Phone ( ) _____

Billing Address _____

E-mail _____ Preferred Contact Mobile Phone____

We may contact you by mail, e-mail or text to provide information about product or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Home Phone ____

Work Phone ____

Employer _____ Occupation _____

Employer's Address _____

Work Phone: ( ) _____ Ext _____ Is it ok to call you at work? _____

Referred by _____ Primary Care Physician _____

Emergency Contact _____ Phone # _____

Relationship _____

Ethnicity: ___ Hispanic ___Non-Hispanic or Latino Language: _____

Race: ___African American ___Asian ___American Indian/Native Alaskin
___Native Hawaiian or other Pacific Islander ___White

Preferred Pharmacy: _____ Phone Number _____
Pharmacy Address: _____

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INSURANCE INFORMATION

Primary Insurance to file

Insurance Company Name _____

Insurance Company Address _____

Policy # _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Social Security # or ID # _____ D.O.B _____

Secondary Insurance to file

Insurance Company Name _____

Insurance Company Address _____

Policy # _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Social Security # or ID # _____ D.O.B _____

Please be aware that we will gladly file a claim to your supplemental insurance with the information you provide us with. We will do this one time per visit as a courtesy. If we receive a denial or receive no response at all, in a timely manner, you will be requested to pay the balance. Thank you in advance for your understanding.

To avoid misunderstandings regarding our payment policies, out staff is trained to consistently inform you of the financial payment policies of this office. All payments are required to be collected at the time the service is rendered. You signature below signifies your understanding and willingness to comply with this policy.

Signature: _____ Date: _____

Name: _____ Date: _____

History of Disease

Lungs

Yes No

- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Asthma
- ☐ ☐ Chronic or A.M. Cough

Vascular

- ☐ ☐ High Blood Pressure
- ☐ ☐ Chest Pain / MI / TIA
- ☐ ☐ Heart Murmur / Valve Disease
- ☐ ☐ Palpitation / Irregular or Fast Heart Beat
- ☐ ☐ Pacemaker

Systemic

Yes No

- ☐ ☐ Diabetes
- ☐ ☐ Thyroid Trouble
- ☐ ☐ Kidney / Bladder Problems
- ☐ ☐ Stomach / Bowel Problems
- ☐ ☐ Hepatitis / Yellow Jaundice
- ☐ ☐ Convulsions / Epilepsy / Seizures
- ☐ ☐ Fainting
- ☐ ☐ Glaucoma
- ☐ ☐ Alcohol
- ☐ ☐ AIDS / HIV or Exposure
- ☐ ☐ Phlebitis (History)
- ☐ ☐ Joint Deformity

Skin

- ☐ ☐ Hives
- ☐ ☐ Hay Fever
- ☐ ☐ Skin Cancer, if yes, explain. _____

_____

- ☐ ☐ Do You Smoke? If yes, how much? _____
- ☐ ☐ (Women) Are you pregnant? If yes, expected date? _____
- ☐ ☐ Do you bleed easily?
- ☐ ☐ Do you have any allergies? If yes, list. _____

_____

- ☐ ☐ Do you have any other disease, condition or problems that we should know about? If yes, list. _____

_____

- ☐ ☐ Have you ever had a blood transfusion? If yes, when? _____
- ☐ ☐ Have you ever had any reaction to a local anesthetic? If yes, explain. _____

_____

- ☐ ☐ Have you been instructed to take any prophylactic antibiotics prior to surgical procedure? If yes, why? _____

Drug History

_____ Steroids	_____ Arthritic Medications	_____ Diabetic Medication
_____ Birth Control Pills	_____ Tranquilizers	_____ Thyroid Medication
_____ Anti-Coagulants	_____ Narcotics	_____ Blood Pressure Medication
_____ Heart Medication	_____ IV or Recreational Drugs	_____ Aspirin / Blood Thinners (Persantine, Coumadin, etc...)

Current Medications: _____

_____

_____

Recent Operations (past 10 years): _____

_____

Describe your skin problem: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Rosario and staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (PTO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Rosario and staff reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Offer at 4479 Baymeadows Rd., Jacksonville, Fl. 32217

I acknowledge and agree that the practice may disclose patient's protected health information and patient's medical record information to the following individuals who are either the patient's family members, legal representative guardians, health care surrogates, or have power of attorney on behalf of the patient:

Patient's Last and First Name	D.O.B	
Name of Individual #1	Relationship	Phone Number
Name of Individual #2	Relationship	Phone Number
Name of Individual #3	Relationship	Phone Number

I GIVE PERMISSION TO DISCLOSE THE FOLLOWING INFORMATION; PLEASE INITIAL ONLY THOSE THAT APPLY

___ Contact Information ___ Appointment Information ___ Insurance Information

___ Visit Notes ___ Prescription Information ___ Patient History

___ Test Results ___ Billing Information

By signing this form, you are agreeing and giving consent to the practice to release information to the patient in the following alternative manners.

1. Via fax; if the patient, any individual listed above in the consent form or to assist the practice in carrying out PTO.
2. Via regular mail to the patient's home address or any other designated location, any item that assist the practice carrying out PTO.
3. Via telephone, if patient contacts the practice and provides the appropriate information (including the patient's name, social security number and date of birth)

_____ _____ _____

Patient's Name Signature of Patient or Legal Guardian Date

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No Show/Cancellation Policy Office Visit

Please be advised that in order to accommodate our patients, we require 24 hours notice if canceling an appointment. If we do not receive proper notice, you may be subject to a cancellation/no show fee. As a courtesy the first occurrence will be waived, the second will result in $25.00 fee, and $50.00 for subsequence results. Additionally, any prepaid cosmetic procedure will forfeit their deposit if not canceled before 24 hours. Please feel free to address any questions you may have regarding this policy with our staff. Your signature below acknowledges your willingness to comply with this policy.

X_____

No Show/Cancellation Surgery Appointment

Please be advised that in order to accommodate our patients, we require 48 hours notice if canceling a surgery appointment. If we do not receive proper notice, you may be subject to a cancellation/no show fee of $75.00. Additionally, any prepaid cosmetic procedure will forfeit their deposit if not canceled before 24 hours. Please feel free to address any questions you may have regarding this policy with our staff. Your signature below acknowledges your willingness to comply with this policy.

X_____

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Date: _____

Patient Name: _____

Please be advised that if our office does any procedure that requires us to send a specimen to a lab, you will have a separate bill from the lab. This cost will be in addition to the charges from our office. If you have a question regarding the bill from the lab, you will need to contact the lab and discuss it with them directly.

By signing this form, I understand that I will be receiving a separate bill from the lab for which my specimens were sent.

This form will stay in my chart with the understanding that this applies to all my future visits also.

_____
Signature