PATIENT INFORMATION

Name: _____ Date of Birth: _____

Email: _____ Social Security #: _____

Cell Phone:_____ Home/Work Phone: _____

Preferred Contact Number & Method: _____ ☐ Text ☐ Email ☐ Cell ☐ Home

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

LOCAL ADDRESS: _____

OTHER ADDRESS: _____

Referred By: ☐ Friend ☐ Family ☐ Website/Internet ☐ TV ☐ Radio ☐ Print Ad ☐ Doctor:_____

Primary Care Doctor Name & Phone: _____

Emergency Contact Name & Phone: _____

Employer Name & Phone: _____

_____ **FINANCIAL POLICY for ALL PATIENTS**: Payment for services is due in full at the time service is provided. We respectfully request 24-hr advance notice if you need to cancel or reschedule – this is especially important for surgery and aesthetic procedures. Failure to provide notice of a need to cancel may result in charge for the missed appointment.

_____ **FINANCIAL POLICY for INSURANCE PATIENTS**: We will bill most insurances if provided with all required information, authorizations, documentation, and any required prior authorizations. Prior authorization may be required prior to scheduling surgery or other procedures. Co-payments, co-insurance and deductibles are collected the day of your service. Your insurance is a private agreement between you and your insurance. We do not routinely research why your insurance has not paid or paid less than anticipated. You may be responsible for the following:

- Non-covered services – any care not paid for by your insurance company under your coverage.
- Full Body Exam – periodic preventative health checks may or may not be covered under your policy; however, they may be recommended by your Provider.

☐ Y ☐ N → *Have you given us a copy of your Insurance Card(s)?*

1st INSURANCE NAME: _____ Are you the Primary Insured: ☐ Y ☐ N

if No, name of Insured is:_____ Relationship: _____

2nd INSURANCE NAME: _____Are you the Primary Insured: ☐ Y ☐ N

if No, name of Insured is:_____ Relationship: _____

Assignment of Insurance Benefits – please read and sign below:

"I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am untitled, private insurance, and any other health plans, to Advanced Dermatology and Skin Surgery Specialists, PA (dba Yag-Howard Dermatology and Aesthetic Center). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment."

Signature: _____ Date:_____

MEDICAL HISTORY – please check all that apply.

	Anxiety / Depression		Heart Disease		Cancer		Liver Disease
	Breathing Disorder		Hypertension		-type:		Hepatitis
	Diabetes		Stroke		-type:		Hyperthyroidism
	Autoimmune Disease		Defibrillator		Radiation Treatment		Hypothyroidism
	Lyme Disease		Pacemaker		Bone Marrow Transplant		Hepatitis
	HIV / AIDS		Bleeding Disorder		Arthritis		Renal Disease
	Pigment Disorder		Poor Wound Healing		Joint Replacement		Seizures
Other:							
☐ *Check here is NONE of the above are applicable*							

SKIN HISTORY – please check all that apply.

	Atypical Moles		Acne		Shingles		Eczema
	Basal Cell Carcinoma		AKs (Actinic Keratosis)		Genital Warts		Psoriasis
	Squamous Cell Carcinoma		Blistering Sunburns		Cold Sores		Scalp Conditions
	Melanoma		Poor Wound Healing				
Other:							
☐ *Check here is NONE of the above are applicable*							

MELANOMA HISTORY:

Location	When	From Whom May We Request Records?

MEDICATION & VITAMIN HISTORY: -- please list what you are taking, dosage strengths and how often.

We can attach your list if you brought it.		

ALLERGIES:_____

_____

_____

PHARMACY:

Name: _____ Phone: _____

SOCIAL HISTORY – please check **each**.

	YES	NO			YES	NO
Wear Sunglasses				Wear Sunscreen – what SPF?		
Drink Caffeine				Use Tanning Salons		
Current Tobacco Use?				Use Tanning Lotions		
- Detail:				Sexually Active		
Prior Tobacco Use?				- Safe Sex		
- Detail:				- Multiple Partners		
- How much? Quit?				Feel Safe at Home		
Driving Restrictions				Alcohol Consumption		
Use illicit drugs				- Socially 1-3/week		
Exercise				- Daily		
- Occasionally				- 5 or more drinks more than3/year		
- 3-5 times/week						

FAMILY HISTORY – and relationship to you – mother, father, brother, sister, grandmother, grandfather, etc.:

Cancer		Skin Conditions	
-type		Heart Disease	
Melanoma		Diabetes	
OTHER:			

SHARING YOUR INFORMATION:

YES	NO	In the interest of ensuring comprehensive medical care, I give Advanced Dermatology and Skin Surgery Specialists PA (dba Yag-Howard Dermatology and Aesthetic Center) permission to:
		Leave a message at my Preferred Contact # concerning biopsy results, lab tests, or any other protected health information (PHI).
		Share my PHI with other health care providers, laboratories, pathology offices and related medical service providers as necessary.
		Share my PHI with insurance companies.
		Discuss my biopsy results, lab tests, or any other PHI with the following people: (NAME / RELATIONSHIP)
		-
		-
		-

HIPAA CONSENT:

Our Notice of Privacy Practices provides information about how we may use and disclose "protected health information" or "PHI" about you The Notice contains a Patients' Right 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 out 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 healthcare 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 (PHI) about you for treatment, your treatment between our practice and other healthcare providers involved in your care, payment, and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, revocation shall not affect any disclosures we have already made in reliance on your prior consent. Advanced Dermatology and Skin Surgery Specialists PA 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 healthcare operations.
- Protected health information may be disclosed between our practice and patient's other healthcare providers.
- 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 Notices of Privacy Practices.
- Patient has the right to restrict uses of their information but the Practice does not have to agree to 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 execution of this Consent.

Patient Name: _____ Witness Name: _____

Patient Signature/Date: _____ Witness Signature:_____

PHOTO CONSENT – your photos may be taken as part of your medical record.

In her medical leadership roles as a faculty member of the University of South Florida College of Medicine, a member of the American Academy of Dermatology Board of Directors, and Chair of the Dermatology Section Council (representing the nation's Dermatologists at the AMA), Dr. Yag-Howard frequently gives educational lectures and publishes educational and research articles in international peer reviewed and scientific journals. Her primary focus is on teaching advanced and innovative surgical techniques, ways to achieve the most cosmetically pleasing outcomes, and methods to optimize wound care. In order to continue serving as an educator, lecturer and author, she relies on the use of clinical photographs to document surgical techniques and outcomes. Under no circumstances are patients identifiable in the photographs. No name is associated with this the photo or used in the verbal or printed communications and identifying features such as eyes are obscured from the photos.

Your signature gives Dr. Yag-Howard your consent to take and use of your photos for the medical education, science or research detailed above. You may change or rescind your consent at any time.

I give my Consent to take and use my photos as detailed above. _____ /_____
Signature of Patient Date

IF YOU ARE NOT THE PATIENT, what is your Name & Relationship: _____

Thank you for completing this important information.
It helps us provide you with the very best care.

YAG-HOWARD