GARDENS DERMATOLOGY
& COSMETIC SURGERY CENTER

Patient Name:			
Address:		City/State/Zip	
Age:	Birth date:	Home#:	Cell#:
Email:		SSN#:	
Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			Gender: ☐ Male ☐ Female
Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Other			
Ethnicity: ☐ Non-Hispanic or Non-Latino ☐ Hispanic or Latino			
Employed by:		Occupation:	
Emergency Contact:		Relation:	Phone#:
Who may we thank for referring you?			
Reason for today's visit:			

MEDICAL HISTORY

(CHECK ALL THAT APPLY)

☐ Anxiety	☐ Coronary Artery Disease	☐ Hypothyroidism
☐ Arthritis	☐ Depression	☐ Leukemia
☐ Artificial Joints	☐ Diabetes	☐ Lung Cancer
☐ Asthma	☐ End Stage Renal Disease	☐ Lymphoma
☐ Atrial Fibrillation	☐ GERD (Acid Reflux)	☐ Pacemaker
☐ BPH (Benign Prostatic Hyperplasia)	☐ Hearing Loss	☐ Prostate Cancer
☐ Bone Marrow Transplantation	☐ Hepatitis: If yes, type	☐ Radiation Treatment
☐ Breast Cancer	☐ Hypertension	☐ Seizures
☐ Colon Cancer	☐ HIV/AIDS	☐ Stroke
☐ COPD (Emphysema)	☐ Hypercholesterolemia	☐ None
☐ HIV/AIDS	☐ Hyperthyroidism	☐ Other:

SURGICAL HISTORY

(CHECK ALL THAT APPLY)

☐ None	☐ Heart: Coronary Artery Bypass	☐ Ovaries: Ovarian Cyst
☐ Appendix Removal	☐ Heart: Heart Transplant	☐ Pancreas: Pancreatectomy
☐ Bladder (Cystectomy)	☐ Heart: Mechanical Valve Replacement	☐ Prostate: Prostate Biopsy
☐ Breast: Biopsy	☐ Heart: PTCA	☐ Prostate: Prostate Cancer
☐ Breast: Lumpectomy (both)	☐ Joint: Hip (☐ both, ☐ left, ☐ right)	☐ Prostate: TURP
☐ Breast: Lumpectomy (left)	☐ Joint: Knee (☐ both, ☐ left, ☐ right)	☐ Rectum: Low Anterior Resection
☐ Breast: Lumpectomy (right)	☐ Kidney: Biopsy	☐ Skin: Basal Cell Carcinoma
☐ Breast Mastectomy (both)	☐ Kidney: Kidney Stone Removal	☐ Skin: Melanoma
☐ Breast: Mastectomy (left)	☐ Kidney: Kidney Transplant	☐ Skin: Skin Biopsy
☐ Breast: Mastectomy (right)	☐ Kidney: Nephrectomy	☐ Skin: Squamous Cell Carcinoma
☐ Colon: Colon Cancer Resection	☐ Liver: Hepatectomy	☐ Spleen: Splenectomy
☐ Colon: Diverticulitis	☐ Liver: Liver Transplant	☐ Testicles (Orchiectomy)
☐ Colon: Colostomy	☐ Liver: Shunt	☐ Uterus: Fibroids
☐ Gallbladder Removal	☐ Ovaries: Endometriosis	☐ Uterus: Uterine Cancer
☐ Heart: Biological Valve Replacement	☐ Ovaries: Ovarian Cancer	☐ Uterus: Cervical Cancer
☐ Other:		

SKIN DISEASE

(CHECK ALL THAT APPLY)

☐ None	☐ Blistering Sunburns	☐ Melanoma
☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratosis	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Basal Cell Skin Cancer	☐ Hay Fever / Allergies	☐ Squamous Cell Skin Cancer
☐ Other:		
Do you wear sunscreen ☐ Yes ☐ No If yes, what SPF _____		Do you tan in a tanning salon? ☐ Yes ☐ No

FAMILY HISTORY

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

☐ Mother ☐ Father	☐ Daughter ☐ Son	☐ Niece ☐ Nephew
☐ Sister ☐ Brother	☐ Aunt ☐ Uncle	☐ Other:
☐ Grandmother ☐ Grandfather	☐ Grandson ☐ Granddaughter	

MEDICATIONS

Please list (or show us your own printed record) of all prescription and non-prescription medications, vitamins, etc.

Pharmacy Name:_____ **Phone**:_____

Do you pre-medicate before any dental or surgical procedures? ☐ Yes ☐ No

List all allergies or ☐ No Allergies _____

SOCIAL HISTORY

(CHECK ALL THAT APPLY)

Smoking Status			
☐ Never ☐ Former ☐ Current smoker # packs per day_____ #of years _____			
Social History Details			
☐ Not sexually active ☐ Sexually active with one partner ☐ Sexually active with more than one partner			
☐ Drug Use ☐ IV Drug Use			
☐ Alcohol – none	☐ less than 1 drink/day	☐ 1-2 drinks / day	☐ – 3 or more drinks /day
Do you feel safe at home? ☐ Yes ☐ No		☐ Drives in daytime	☐ Drives at night
How often do you exercise?			
What is your caffeine use?			

In order to serve your needs to the fullest, please check the topics you would like to discuss or would like further information.

☐ Botox and/or Dysport	☐ Skin Cancer Information
☐ Fillers: Restylane, Juvederm, Voluma	☐ Scar Treatments
☐ Laser Resurfacing & Photo rejuvenation	☐ Chemical Peels
☐ Vein Treatment	☐ Skin Tightening Treatments
☐ Psoriasis / Eczema	☐ Microdermabrasion / facials
☐ Lesion Removal	☐ Earlobe Repair/ Ear Piercing
☐ Laser Hair Removal	☐ Other:

INSURANCE INFORMATION

The insurance card must be presented for insurance filing purposes or the claim will be considered self-pay. The following must be completed in full so that we may process your insurance information correctly. The information supplied below should be for the person who holds the insurance policy. Provided you are the policy holder, or on the policy, please sign at the bottom. A parent or guardian must sign for a minor patient.

Person responsible for insurance:_____

Birth date:_____ Sex: ☐ Male ☐ Female SSN:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Employed By:_____Phone:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have coverage with the insurance company with whom I have provided information and presented my insurance card. I assign directly to the providers at Gardens Dermatology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges necessary to secure all payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that any co-payments, co-insurance or deductibles that may be applied by my insurance are my responsibility and payment is to be made at the time of service.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date

GARDENS DERMATOLOGY
& COSMETIC SURGERY CENTER

PATIENT CONSENT for USE and DISCLOSURE of PROTECTED HEALTH INFORMATION

With my consent, Gardens Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Gardens Dermatology's Notice of Privacy Practice 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. Gardens Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to the Gardens Dermatology Privacy Office at 11030 RCA Center Drive, Suite 3015, Palm Beach Gardens, FL 33410.

With my consent, Gardens Dermatology may call my home or other designated location and leave a message on my voicemail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any issue pertaining to my clinical care, including laboratory results or medications, etc.

With my consent, Gardens Dermatology may send mail to my home or other designated location. These items include but are not limited to carrying out TPO: for example, appointment reminder cards and patient statements.

I have the right to request that Gardens Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Gardens Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Gardens Dermatology may decline to provide treatment to me.

_____Signature of Patient or Legal Guardian

_____Print Patient's Name _____Date

With my consent, Gardens Dermatology may release information pertaining to my clinical care including laboratory results to the person(s) listed below.

1.) _____ 3).____

2.) _____ 4.)_____

_____Signature of Patient or Legal Guardian

_____Print Patient's Name _____Date

FOR OFFICE USE ONLY	
Pt DOB	Pt Medical Record #

Print Form Clear Form Save Form