



Gardens Dermatology & Cosmetic Surgery Center

11030 RCA Center Drive, Suite 3015  
Palm Beach Gardens, FL 33410  
Phone (561) 776-7041  
Fax (561) 776-7043



Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Information

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Single: \_\_\_\_\_ Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Please tell us about yourself...

Please list all medications (including prescriptions and over the counter medications- Aspirin, Motrin, etc.), vitamins, or herbs you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Are you applying any topical medications of any kind (creams, ointments, etc.) to your skin? \_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to medications? \_\_\_\_\_

Do you have any active or chronic medical conditions, including a pacemaker, ulcer, diabetes, high blood pressure, artificial joints, heart murmur, etc.? \_\_\_\_\_  
\_\_\_\_\_

Do you premedicate with antibiotics before having surgery or dental procedures? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have a personal history of skin cancer? YES \_\_\_\_\_ NO \_\_\_\_\_ Type: \_\_\_\_\_

If yes, did you ever have surgery to remove? YES \_\_\_\_\_ NO \_\_\_\_\_ Location: \_\_\_\_\_

Do you have a family history of melanoma or other skin cancer? YES \_\_\_\_\_ NO \_\_\_\_\_

What is the name and number of your pharmacy? \_\_\_\_\_



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**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:**

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Last	First	Middle
Birthdate: _____/_____/_____		
Sex: _____M_____F	SS#: _____	
Address: _____		
Home Phone: _____		Cell Phone: _____
Employed By: _____		
Business Address: _____		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 whether or not paid by insurance. I hereby authorize the doctor to release all information 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 apply to my insurance are my responsibility and payment is to be made at the time of service.

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Responsible Party Signature	Relationship to Patient	Date
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**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 Practice 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 voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

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: appointment reminder cards and patient statements, for example.

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

\_\_\_\_\_

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.

\_\_\_\_\_

Name of Person

\_\_\_\_\_

Relationship



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**Patient Questionnaire**

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

Skin Cancer Information

Botox

Restylane, Perlane, Juvederm, Radiesse, and Other Fillers for Wrinkles and Lines

N-Lite Wrinkle Treatment

Laser Resurfacing & Photorejuvenation

Psoriasis / Eczema

Lesion Removal

Vein Treatments

Tattoo Removal

Scar Treatments

Earlobe Repair

We offer a complimentary consultation for the following services. Please complete if you would like to schedule a consultation with an Aesthetician.

Permanent Make-up

Skin Care Regime / Product Information

gloMinerals Make-up

Ear Piercing

Facials

Pre-Wedding Skin Care

Microdermabrasion

Chemical Peels