SAND LAKE DERMATOLOGY CENTER, P.A.
7335 W. SAND LAKE ROAD, SUITE 200
ORLANDO, FL 32819

PATIENT INFORMATION

PHONE: (407) 352-8553
FAX: (407) 351-8412

☐ MR ☐ MRS ☐ MS ☐ DR Patient Name			Sex / **Primary Phone for Appointment Reminders**
Address			Alternate Phone
City	State	Zip	Preferred Contact Method: ☐ Phone Call ☐ Email ☐ Text Message
Employer/School	Occupation		Age Date of Birth
E-Mail Address		E-Mail Monthly Specials? ☐ Yes ☐ No	SS No.
Name of Parent/Spouse		**Patient's Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Address	City	State	Zip
In Case of Emergency Contact:	Relationship	Phone	

Referred By: (Please Circle)
Doctor_____ Family/Friend_____ Insurance Plan Yellow Pages Newspaper Ad Internet Other_____

INSURANCE INFORMATION

Please give insurance cards to receptionist to copy.

Insurance Company Name ☐ UHC ☐ BCBS ☐ Cigna ☐ Aetna ☐ Medicare ☐ Other Primary: Insured's Name:_____ DOB_____	Secondary: Insured's Name:_____ DOB_____

Do we have permission to:

Leave a message on your answering machine?	☐ Yes	☐ No
Leave a message with a family member?	☐ Yes	☐ No
Leave a message at work?	☐ Yes	☐ No

Medical treatment/information may be discussed/disclosed to whom?

Name _____ Relationship _____

Name _____ Relationship _____

Pharmacy Name_____ Phone_____

Address_____

Would you like more information about: (please circle) Microneedling | Dermaplaning

Facial Rejuvenation | Sunscreen | Wrinkle Reduction | Botox | Cosmetic Fillers | Vein Treatment | Facial Products

Cosmetic Consultation | Oxygen Facial | Chemical Peels | Laser Hair Reduction | Microdermabrasion

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 Sand Lake Dermatology for services performed.

Signature_____ Date_____

Sand Lake Dermatology Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Sand Lake Dermatology Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Sand Lake Dermatology Center's 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. Sand Lake Dermatology Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sand Lake Dermatology Center's Privacy Officer at 7335 W. Sand Lake Road, Suite 200, Orlando, FL 32819.

With my consent, Sand Lake Dermatology Center may call my home or other designated location and leave a message on 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, Sand Lake Dermatology Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Sand Lake Dermatology Center may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right request that Sand Lake Dermatology Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Sand Lake Dermatology Center'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, Sand Lake Dermatology Center may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. We believe that in the interest of an ongoing mutually satisfying doctor/patient relationship, it is important to clearly state the terms of our service. We request you read and sign the following financial policy prior to treatment.

Patients or responsible party must complete our information forms before seeing the provider.

FULL PAYMENT, CO-PAYMENT, PERCENTAGES AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA/MASTERCARD AND DISCOVER.

We realize that your time is valuable and that long delays in the schedule are unacceptable. We do our best to schedule carefully and to confirm appointments when possible. Emergencies do arise in a dermatology practice, but a major cause of scheduling disruption is missed appointments. We do not want to resort to over-booking to cover these "no shows", so it is urgently important that you cancel/reschedule appointments at least 24 business hours in advance. **There is a $48 charge for all missed appointments or appointments not cancelled or rescheduled at least 24 business hours in advance.** Consecutive "no-shows" will result in dismissal from the practice.

There is a $35 charge for checks returned for insufficient funds.

The treatment of minors must be authorized by the signature of a parent or legal guardian on medical history, financial policy, insurance and consent forms prior to treatment. Subsequent charges may be handled by pre-authorized credit card, check or cash.

For insurance office policies, please read whichever applies to you:

INSURANCE (PARTICIPATING COMPANIES):

As a participating provider, the contract for service is between the insurance company and Sand Lake Dermatology Center. We are contractually required to collect co-payments/percentages/deductibles at the time of service.

Please be aware that some of the services provided may be considered by your plan to be "non-covered" or "not medically necessary". Therefore, you will be expected to pay for them at the time of service.

If your insurance coverage changes to a plan in which we are not a participating provider, you will be expected to pay in full at the time of service.

INSURANCE (NON-PARTICIPATING COMPANIES):

Your insurance policy is a contract between you and your insurance company, and Sand Lake Dermatology Center is not a party to that contract.

You are responsible for full payment of the charges at the time of service. For your convenience, however, we will file your claim for you and your insurance company can reimburse you directly, based on the specifics of your insurance policy.

Our practice is committed to providing the best treatment for our patients and we charge what we consider appropriate for the expertise involved in your care. You are responsible for payment regardless of any insurance company's arbitrary determination of "allowed" or "usual and customary" rates.

Signature _____ Date_____

Sand Lake Dermatology Center, P.A.

Past Medical History: *(please circle all that apply)*

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Polycystic Ovarian Syndrome
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
Other _____
None

Past Surgical History: *(please circle all that apply)*

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Other _____
None

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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
Hair Loss
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other _____
None

Do you wear Sunscreen? (please circle) Daily / Occasionally / Seldom / Never
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

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

What is your current skin care regimen?
AM Routine _____
PM Routine _____

Medications: *(please enter all current medications)*

Allergies: *(please enter all allergies)*

Sand Lake Dermatology Center, P.A.

Social History: *(please circle all that apply)*

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Sexual History:

- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same gender partner

Illicit Drug Use:

- Drug Use
- IV Drug Use

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:

- I feel safe at home.
- I do not feel safe at home.

Other _____

Demographics: (Please circle all that apply)

Race:

- White
- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Other
- Declined to Specify

Ethnic Group:

- Hispanic or Latino
- Non Hispanic or Latino
- Declined to Specify

Preferred Language _____

Preferred Contact Method:

- Phone
- Fax
- Letter
- Email