SUN DERMATOLOGY
MOHS SURGERY | GENERAL | COSMETIC

645 North Highway 231, Panama City, FL 32405 Phone: 850-215-3612 Fax: 850-215-4533

Name____ Date of birth_____/_____/______ Age_____ Sex ____

Mailing Address_________________________________ Apt #__________ City______________ State____ Zip _______

Home Phone______________________________________ Cell Phone____

Employer ____ Employer Phone__________________________

SSN ______________________________ Race______________________ Ethnic Group______________________

Emergency Contact___________________________________ Emergency Contact Phone______________________

Primary Physician________________________________ Referring Physician___________________________________

*Primary Insurance____ ID Number _______________________________

Cardholder's Name____ Cardholder's SSN________________________

Relationship to Patient___________________________________ Cardholder's Date of Birth___________________

*Secondary Insurance_____________________________________ ID Number ________________________________

Cardholder's Name ____ Cardholder's SSN ________________________

Relationship to Patient ____ Cardholder's DOB ___________________

When calling with results, is it okay to leave a detailed message? **YES** **NO**
How did you hear about Sun Dermatology? _______________________________________

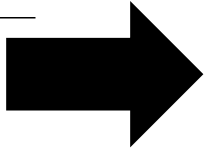
IF PATIENT IS UNDER THE AGE OF 18, PROVIDE THE FOLLOWING INFORMATION FOR THE GUARANTOR:
Guarantor Name: _______________________ Date of Birth: ___/___/___ Preferred Phone: ____-____-_____
Address: ____ Relationship to Patient: __________

RECEIPT OF NOTICE OF PRIVACY PRACTICES:
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

PAYMENT POLICY: I hereby authorize my insurance benefits, including Medicare, to be paid directly to Sun Dermatology. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I hereby Authorize said assigned to release all information necessary to secure that payment. In the event that this account is assigned to collections, I agree to pay all costs of collection including reasonable attorney fees.
You will be responsible for paying your annual deductible, co-payment and charges for any non-covered and cosmetic services at the time of service.

PLEASE BE ADVISED: THERE MAY BE ADDITIONAL COSTS FROM AN EXTERNAL LABORATORY IF A BIOPSY OR CULTURE OF ANY KIND IS PERFORMED.

Patient or Responsible Party Signature ____________________________________ **Date** ________________



Medical Records Release

Please list all persons to whom we may disclose your personal health information:

______________________________ ________________ ____-____-_____
Name: Relationship: Preferred Phone:

______________________________ ________________ ____-____-_____
Name: Relationship: Preferred Phone:

For access to your records and results via your Patient Portal please provide us with an active email address that we can associate with your Patient Portal. You will receive an email providing you with access upon activation of your account.

Email Address: ____

Medication History Consent

I hereby give permission to Sun Dermatology to request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Signature: ________________________________ Date: ______________

Pharmacy Information

In the event a prescription is needed please list a preferred pharmacy:

Pharmacy Name: ____

Location: ____

Phone: ____

Cosmetics

Would you like to be notified via e-mail or phone about cosmetic events and specials? If so please fill in the information below:

Email Address:______________________________________ Contact Number:_________________________

Name ________________________

Patient Consent for Medical Photography

Please check one or all that apply

- ☐ Check here if minor or unable to provide consent:
  I consent for medical photographs to be made of my child (or the person that I am a legal guardian to/Durable Power of Attorney)

- ☐ I consent to the use of my photographs for my medical records **ONLY (required for treatment by Sun Dermatology)**

- ☐ I consent for my photographs to be used for academic purposes that include but not limited to medical publications, electronic publications, teaching purposes and my medical records. I understand that the images may be seen by the general public, in addition to scientists and medical researchers. I understand that although these images will be used without identifying information such as name, it is still possible that someone may recognize me.

- ☐ I consent for my photographs to be used in cosmetic purposes that include but not limited to before and after examples, cosmetic social media marketing, and general cosmetic marketing.

Patient Signature____ Date_______________

APPOINTMENT CANCELLATION POLICY AGREEMENT

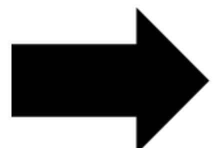
Sun Dermatology is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.
PLEASE call us at (850) 215-3612, 24 hours before your scheduled appointment to notify us of any changes or cancellations**. To cancel a Monday appointment, please call our office by 11:00 P.M. on Friday.** If prior notification is not given, you will be charged $30 for the missed appointment.

*****For Cosmetic appointments (60 minutes or longer) --- A deposit of 25% or $350 is required (whichever is greater)**

By signing below, I consent to the above terms

Patient Signature____ Date_______________

Patient's Parent/Guardian if under 18_____________________________Date_______________



Name____

Medical History – check all that apply
o Anxiety
o Arthritis
o Asthma
o Atrial fibrillation
o COPD
o Coronary arteriosclerosis
o Depression
o Diabetes
o Hypertension
o GERD
o Hearing loss
o HIV/AIDS
o Hyperthyroidism or hypothyroidism
o Cancer: ____________________________________

Surgical History – check all that apply
o Appendectomy
o Coronary artery bypass
o Delivery by C -Section
o Gallbladder removal
o Heart valve replacement
o Hysterectomy
o Hip joint replacement:
Left Right Both
o Knee joint replacement:
Left Right Both
o Kidney transplant
o Liver transplant
o Mastectomy
o Tubal ligation

Other Medical History:
____

Skin Disease History – check all that apply
o Acne
o Actinic keratosis
o Basal cell skin cancer
o Dysplastic nevus
o Eczema
o Melanoma
o Flaking/Itchy scalp
o Psoriasis
o Squamous cell skin cancer

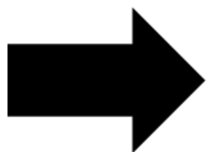
Social History:
Smoking Status:
o Never smoker
o Former smoker
o Current smoker
Alcohol Consumption:
o None
o Less than 1 drink per day
o 1-2 drinks per day
o 3 or more drinks per day

Do you wear sunscreen? **Yes or No** if yes, what SPF? ____
Do you tan in a tanning salon? **Yes or No**
Do you have a family history of Melanoma? **Yes or No** If yes which relative? _______

Please list any current medications (i.e., Aspirin 81 mg once daily)
____
____

Allergies: ____

What brings you in today?
____



Vaccination Status

Have you received your pneumonia vaccine? **Yes or No**

Have you received your flu vaccine? **Yes or No**

Advanced Directives

Advanced Directives are designed to respect your wishes about life-saving medical treatment if you are unconscious or incapacitated. Select one or more of the following options:

_____ **Full Cardiopulmonary Resuscitation:** I want full Cardiopulmonary Resuscitation (CPR) efforts to be made (Full Code)

_____ **Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an external defibrillator to restart my heart, even if it is necessary to save my life.

_____ **Do Not Intubate:** I do not wish to have a breathing tube inserted, even if it is necessary to save my life.

Do you have a health care proxy in the event you are unable to make your own medical decisions? **Yes or No**

Proxy's Name: ___________________________________

Proxy's Phone Number: ____________________________

Do you have a living will? **Yes or No**

Patient Signature: ___________________________________ Date: _______________