Monica K Bedi, MD
Ann Neff, MD
Jean Pierre Galliani, MD
Naomi Johansen, MD
Margarita Givens, PA-C
Laura De Oliveira, PA-C
Anna Heck, PA-C

PLEASE PRINT. Date: _____

PATIENT INFORMATION

Name: _____ Social Security: _____
Birthdate: _____ Age: _____ Sex: Male ☐ Female ☐
Address: _____
State/City/Zip: _____
Home phone: _____ Cell Phone: _____ Work phone: _____
Which is your primary number? _____ Email: _____

Parent/Guardian Name (if under 18): _____
Address: _____
State/City/Zip: _____
Home phone: _____ Cell Phone: _____ Work phone: _____
Which is your primary number? _____ Email: _____

Employer: _____
Address: _____
State/City/Zip: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Insurance ID Number: _____ Group Number: _____
Subscriber Name: _____
Subscriber Social Security Number: _____
Subscriber Date of Birth: _____Subscriber Relation to Patient: _____

Secondary Insurance Name: _____
Insurance ID Number: _____
Subscriber Name: _____
Subscriber Social Security Number: _____
Subscriber Date of Birth: _____Subscriber Relation to Patient: _____

Primary Care Physician: _____ Phone Number: _____
Referred to us by: _____ Phone Number: _____

Preferred Pharmacy: _____
Address or cross streets: _____
Phone Number: _____ Fax Number: _____

Do we have permission to:

Leave a message on your home answering machine? ☐ Yes ☐ No
Leave a message at your place of employment? ☐ Yes ☐ No
Discuss your medical information with any one else? ☐ Yes ☐ No

If so, to whom: _____ Relationship: _____

DERMATOLOGY associates

Monica K Bedi, MD
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Laura De Oliveira, PA-C
Anna Heck, PA-C

MEDICAL QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Reason for Today's Visit: _____

DO YOU HAVE NOW OR HAVE YOU HAD A HISTORY OF THE FOLLOWING CONDITIONS? PLEASE CHECK ONLY THOSE THAT APPLY:

- ☐ Immunosupression
- ☐ Skin Pre-cancers (actinic keratosis)
- ☐ Irregular Moles (dysplastic nevus)
- ☐ Melanoma
- ☐ Skin Cancer (basal or squamous)
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Atrial Fib/Flutter
- ☐ Heart Attack/Stents
- ☐ High Cholesterol
- ☐ Joint Replacement
  Site _____
  Year _____
- ☐ Asthma
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Multiple Sclerosis
- ☐ Bowel Disease
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Hayfever / Allergies
- ☐ Lupus
- ☐ HIV
- ☐ Stroke
- ☐ Seizures
- ☐ Depression
- ☐ Rheumatologic Disorder
- ☐ Organ Transplant
  *Type:*_____
- ☐ Glaucoma
- ☐ Cancer (ex. breast)
  *Type:*_____
- ☐ Radiation Treatment
- ☐ Blood disorders
- ☐ Eczema
- ☐ Psoriasis

*Other:*_____

Are you allergic to any medications? If yes, please list:
_____
_____

Are you allergic to tape/ointments? Yes / No

Previous surgeries: _____
_____

Please list your current medications, including herbs and vitamins, or give a list:
_____
_____
_____
_____
_____
_____

Any additional comments or something we should know:
_____
_____

DO YOU HAVE A HISTORY OF BLISTERING SUNBURNS? Yes / No **DO YOU HAVE A HISTORY OF TANNING BED USE?** Yes / No

ARE YOU INTERESTED IN ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

- ☐ BOTOX® Cosmetic
- ☐ Chemical Peels
- ☐ Laser Hair Removal
- ☐ Skin Care Products
- ☐ SculpSure Fat Sculpting
- ☐ Facials

DO ANY FAMILY MEMBERS HAVE A HISTORY OF THE FOLLOWING CONDITIONS?:

Melanoma Yes / No Skin Cancer Yes / No Psoriasis Yes / No Lupus Yes / No
Eczema Yes / No Hair Loss Yes / No Thyroid Disease Yes / No

WHERE DID YOU GROW UP? _____ **I HAVE LIVED IN FLORIDA SINCE WHAT YEAR?** _____

DO YOU PERSONALLY USE THE FOLLOWING?: Sunscreen Yes / No Alcohol Yes / No Tobacco Yes / No

MARITAL STATUS: Single ☐ Married ☐ Divorced ☐ Widowed ☐

OCCUPATION: _____ **RACE/ETHNICITY:** _____

ARE YOU INVOLVED IN OUTDOOR ACTIVITIES? Yes / No **IF YES, WHAT ACTIVITIES?** _____

WE RECOMMEND A TOTAL BODY SKIN EXAM FOR ALL NEW PATIENTS IN ORDER TO EVALUATE FOR SKIN CANCERS. WILL YOU BE HAVING A TOTAL BODY SKIN EXAM TODAY?

☐ Yes ☐ No ☐ Next Visit

Assignment of Benefits & Financial Policy

ASSIGNMENT OF BENEFITS

If you have no insurance:

I agree to pay my medical expenses, in full, when I am seen by the physician/physician assistant. If for any reason there is a balance owed on my account, I agree to pay promptly upon receipt of the monthly statement.

If you have Medicare or Medicaid:

I request that payment of authorized Medicare benefits be made on my behalf to the rendering physician for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines to be my responsibility.

If you have HMO, PPO or commercial insurance:

I authorize any holder of medical information about me to release to my insurance company or its agents any information (including HIV, alcohol, and mental health) needed to determine benefits payable for related services. I agree to comply with the terms of my insurance coverage, including payment of my co-payment at the time of service rendered and payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement.

If you have Medigap insurance (Medicare Supplement):

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering physician for any services furnished me by that provider. I authorize any holder of medical information about me to release to my Medigap carrier any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services.

STATEMENT OF FINANCIAL RESPONSIBILITY

In addition to our charge for the visit or procedure, if you have a biopsy, surgical specimen, or culture swab taken at any visit, you (or your insurance) will be billed separately by the pathologist or lab for their analysis of the specimen. We will provide your billing and insurance information to the lab or pathologist.

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. Your cooperation in complying with the terms of this assignment will be appreciated.

I, the UNDERSIGNED, have read the above and realize that all medical and surgical charges incurred by me, or my dependents, for services rendered by are my financial responsibility. All court fees, attorney fees, or other fees necessary to collect this account, should it become delinquent, are payable by me. **I am also aware of this office's no-show fee of $25.00. This fee is payable by me should I fail to give 24-hour notice for a scheduled appointment.**

Signed: _____ Date: _____/_____/_____

Witness (by staff): _____

I understand that I will be seen by Monica Bedi, MD, Ann Neff, MD, Naomi Johansen, MD, or Jean Pierre Galliani, MD and/or Laura De Oliveira, PA-C, Margarita Givens, PA-C or Anna Heck, PA-C. I understand that at any time I may choose which provider I schedule my appointment with and be seen by.

Signature: _____ Date: _____

IMPORTANT SUMMARY OF THE PRIVACY OF YOUR HEALTH INFORMATION

Your privacy is extremely important to us. The information that we record about you and your medical history is to help us provide quality medical care. We are committed to protecting this information. The *Notice of Privacy Practices* describes your rights with regards to your health information and our responsibility to protect that information. This is just a summary, but a detailed description of your rights is posted in the waiting area. We would also be happy to provide you with a detailed copy to take with you.

Your rights include:

- The right to amend your health information
- The right to request restrictions on what information we use or how we disclose your health information
- The right to see an account of certain disclosures we have made of your health information
- The right to obtain access to your health information with limited exceptions (A written or notarized request, an appointment for access, appropriate advance notice, and a cost-based fee for expenses delineated by law)
- The right to receive a paper copy of our *Notice of Privacy Practices*

These rights do have certain restrictions and you may obtain detailed disclosure of these restrictions at any time.

We may use your health information and/or records to:

- Plan for your care and help your health care providers communicate and work together for your overall medical benefit
- Submit bills for reimbursement for the care provided to you
- Help health care payers or medical insurance companies verify that services were provided to you
- Help improve the quality of your health care
- Disclose information to certain officials or organizations as requested by law

Everyone working for Monica K. Bedi, MD PA, who has access to your information, is bound by law to uphold to all privacy standards.

We encourage you to read the *Notice of Privacy Practices* and to please ask if you need further information.

Your signature below confirms that you have read and understand your rights to privacy, and that you have been given access to all information pertaining to those rights.

Signature: _____ Date: _____