SUNNYCOAST DERMATOLOGY VERO BEACH

SUNNYCOAST DERMATOLOGY VERO BEACH
Ted Rudolph, M.D.
3900 20th Street (St. Rd 60)
Vero Beach, FL 32960
Tel (772) 299-4000 • Fax (772) 299-4001

# Welcome!

**PATIENT REGISTRATION:** Please present insurance cards & photo I.D. to the receptionist so copies may be made.

**Name** _____ Date _____
First Middle Last

**Permanent Address** _____
Street Apt # City State Zip Code

**Local Address** _____
Street Apt # City State Zip Code

**Permanent Phone** (_____) _____ **Local Phone** (_____)_____

MAY WE LEAVE A PHONE MESSAGE WITH PERSONAL MEDICAL INFORMATION? YES NO

**Gender:** Male Female **May we leave a message at home?** Yes No

**Age** _____ **Date of Birth**_____/_____/_____ **Social Security Number** _____-_____-_____

Please circle your **Marital Status**: Married Single Widowed Divorced

**Spouse's Name** _____ **Spouse's Date of Birth** _____/_____/_____

**Emergency Contact** (other than spouse)_____

**Relationship to Patient**_____ **Phone** (_____)_____

**Are you employed?** Yes No **Employer Name**_____

**May we contact you at work?** Yes No **Work Number**_____ext._____

**May we discuss your medical condition with any member of your family?** Yes No

Our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE,** for "YOUR PART" of the charges. We accept CASH, CHECK, VISA & MASTERCARD. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claim (if any). You herein authorize payment of medical benefits to **SUNNYCOAST DERMATOLOGY, INC.** when a claim is filed. If your account must be turned over for collections, a collection fee will be added to your account.

Signature of Patient or Guardian _____

Date_____ If Signed by Guardian, your Relationship: _____

Patient Relationship to Policy Holder: Self Spouse Child Other

**Who referred you to this office?** _____

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# MEDICAL HISTORY

**Name**_____ Date_____
First Middle Last

**Family Physician** _____ Phone_____

List all **MEDICATIONS** you currently take: including prescriptions, over-the-counter, vitamins & herbals):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

**ALLERGIES**: to any Medications Yes No List_____

**Do you have Prescription Coverage? Yes No**

**Does your Prescription Plan require a 90-day supply? Yes No**

**Name of Pharmacy you use** _____ **Phone**_____

**Circle all MEDICAL CONDITIONS you have or may have had:**

***EYES:***
Cataracts
Glaucoma
Macular Degeneration

***LUNGS/SINUS:***
Asthma
Emphysema/COPD
Sinus Problems

***CARDIOVASCULAR:***
Blood Clots
Cardiac Bypass Surgery
Heart Attack
Heart Stents/Valve
High Blood Pressure
Irregular Heartbeat
Pacemaker

***OTHER SYSTEMIC:***
Allergies/Hay Fever _____ Arthritis/Joint Deformity
Artificial Joint ____ Bladder
Diabetes_____ Kidney
Stroke/CVA or TIA Thyroid
Other Systemic Disease or Condition:_____
_____
_____

***GASTROINTESTINAL/LIVER:***
Colon/Intestinal IBS
Crohn's Disease Hepatitis B or C
Diverticulitis/Diverticulosis
Liver Disease

***PSYCHOLOGICAL/BEHAVIORAL:***
ADD/ADHD ____ Autism
Depression_____ Bipolar
Mental Illness
Ulcer

***CANCER:*** Have you ever had any type of CANCER? Yes No
If Yes, what type? _____

Initials

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# MEDICAL HISTORY (continued)

**Name**_____ Date_____
First Middle Last

**List Major Operations or Recent Hospitalizations** _____

_____

**SKIN: Circle all SKIN CONDITIONS you have or may have had:**

Have you ever had **SKIN CANCER**? Yes No

**Melanoma** **Basal Cell Carcinoma** **Squamous Cell Carcinoma**

Other:_____

Have you been treated for **Actinic Keratoses (AK)**? Yes No

Have you ever had an **abnormal mole**? Yes No

Family history of **skin cancer**? Yes No

Any history of **specific skin disease**? Yes No

**Acne** **Alopecia** **Atopic Dermatitis/Eczema** **Psoriasis** **Keratosis Pilaris**

**Lichen Planus** **Lupus Erythematosus** **Rosacea** **Urticaria/Hives**

Other:_____

Do you require antibiotics prior to dentist? Yes No

Artificial Heart Valve, Pacemaker, or Joint? Yes No

Any problems with healing? Yes No

Any history of keloid scars? Yes No

Do you bleed easily? Yes No

Do you develop skin rashes to Neosporin? Yes No

Do you have trouble with Band-Aids? Yes No

Any bad reaction to local anesthesia? Yes No

What is your **OCCUPATION**:_____

Do You: **drink alcohol?** Yes No if yes how much-how often?_____

**smoke?** Yes No if yes # of packs per day?_____

**use drugs?** Yes No if yes what kind-how often?_____

Do you have or have you been exposed to **HIV (AIDS)**, **HEP C**, or **TB**? Yes No

Are you interested in any of the following cosmetic procedures?

☐ Chemical Peels/Facials ☐ Botox ☐ Collagen/Fillers

**FEMALE PATIENTS**: Are you on Birth Control Pills? Yes No

Pregnant or trying to become Pregnant? Yes No

Prone to Yeast Infection when taking antibiotics? Yes No

Medical History Completed By:

☐ Patient

☐ Parent/Legal Guardian

_____
Signed by Patient Date

_____
Reviewed by Date

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# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE-DESCRIBES HOW MEDICAL INFORMATION ABOUT,YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As requited by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services; in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of you PHI for marketing purposes, including subsidized treatment and health care operations:
- Disclosures that constitute a sale of PHI under HIPPA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentially or unintentionally diclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

I am a patient of **Sunnycoast Dermatology**. I hereby acknowledge receipt of their Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____