PARKS DERMATOLOGY CENTER

Annual Patient History Form

Name:_____ D.O.B.: _____ Date:_____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____Email: _____

Occupation: _____ Employer: _____

Marital Status: _____ Social Security #: _____

Do we have your permission to leave a message regarding test results? ☐ Yes ☐ No

Is there anyone else we can speak with on your behalf? ☐ Yes ☐ No

Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician (PCP): _____ Phone: _____

Any <u>new</u> medical conditions diagnosed in the last 12 months? (i.e., Diabetes, Hypertension, Heart issues)

☐ None ☐ Yes (please specify) _____

Do you have an advance healthcare directive <u>or</u> a living will <u>or</u> a designated decision maker on file with any healthcare provider? ☐ No or Unsure ☐ Yes (please specify) _____

How many times in the past year have you had 4 or more alcoholic drinks in a day?

☐ Never ☐ No Alcohol Use ☐ 1 - 2 days ☐ 3 + days

Are you a tobacco smoker? ☐ Yes ☐ Former ☐ No

Have you had a Pneumonia shot ?

☐ No ☐ Yes, *when* _____ *(year)*

Did you receive an Influenza shot (a.k.a."flu")?

☐ No ☐ Yes, *when* _____ *(year)*

Current Insurance:

Primary Insurance Carrier: _____ Name of Insured (Subscriber): _____

Subscriber DOB: ___/___/___ Subscriber Gender: ☐ M ☐ F Relationship to Patient:_____

PAYMENT OF BENEFITS/ AUTHORIZATION OF TREATMENT

Our Practice teaches dermatology residents from Orange Park Medical Center and they may be involved in your care under the supervision of your physician. However, your physician will direct your care and treatment plan during each visit.

I hereby authorize treatment from any licensed medical professional within Parks Dermatology Center, LLC. I understand that this authorization may be used now or in the future. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. We accept VISA, MasterCard, AMEX, DISCOVER and Care Credit for your convenience. Your signature below indicates that you understand and accept this policy. I request the direct payment of all authorized medical benefits to be made to Parks Dermatology Center for any services I received by the physicians or laboratory of Parks Dermatology Center. I authorize any holder of medical information about me to release this information to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred. Parks Dermatology Center, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature: _____ Date:_____