

**Name:** \_\_\_\_\_ **Nick Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Gender:**  Female  Male  Other **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Birth State:** \_\_\_\_\_  
**Race:** \_\_\_\_\_ **Ethnicity:**  Hispanic  Non-Hispanic  Other: \_\_\_\_\_  Decline  
**Preferred Language (Specify)** \_\_\_\_\_ **Military Service:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_  
**Do we have your permission to leave a voicemail regarding test results?**  Yes  No  
**Phone Preference:**  Home Phone  Cell Phone  
**Is there anyone else we can speak with on your behalf?**  Yes  No  
**Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**ACTIVE CONDITIONS: Are you CURRENTLY receiving treatment for any condition(s) listed below? Check Y or N**

	Y	N		Y	N
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: <i>Please check type: A B C</i>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	HIV (Human Immunodeficiency Virus)	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol (Hypercholesterolemia)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Benign Prostatic Hyperplasia (BPH)	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Lung Disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Arteriosclerosis (Coronary Artery Disease)	<input type="checkbox"/>	<input type="checkbox"/>	Malignant tumor of lung (Lung Cancer)	<input type="checkbox"/>	<input type="checkbox"/>
Depressive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Malignant tumor of Colon (Colon Cancer)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Malignant tumor of Colon (Prostate Cancer)	<input type="checkbox"/>	<input type="checkbox"/>
End-Stage Renal Disease (ESRD)	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Gastroesophageal Reflux Disease (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other:</b> (pregnant, breast feeding, etc.)		
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>			

**PAST SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N**

	Y	N		Y	N
Coronary Artery Bypass Graft (CABG)	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Excision of Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Mechanical heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>
Excision of Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Prostatectomy (prostate removed)	<input type="checkbox"/>	<input type="checkbox"/>
Excision of Squamous Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Splenectomy (spleen removed)	<input type="checkbox"/>	<input type="checkbox"/>
History of tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	Total nephrectomy (kidney removed)	<input type="checkbox"/>	<input type="checkbox"/>
History of Appendectomy (appendix removed)	<input type="checkbox"/>	<input type="checkbox"/>	Total Replacement of Knee: (Left, Right, Both)	<input type="checkbox"/>	<input type="checkbox"/>
History of Cholecystectomy (gallbladder removed)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Transplant History: check all that apply</b> <input type="checkbox"/> Kidney <input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas		
History of Mastectomy: (Left, Right, Both)	<input type="checkbox"/>	<input type="checkbox"/>			
(Hx) Total Replacement of Hip: (Left, Right, Both)	<input type="checkbox"/>	<input type="checkbox"/>			

**SKIN DISEASE HISTORY: Have you ever had any of the following conditions? Check Y or N**

	Y	N		Y	N
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Actinic Keratosis	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Cancer : year/site: _____	<input type="checkbox"/>	<input type="checkbox"/>	Scalp itchy	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Squamous Cell Cancer: year/site: _____	<input type="checkbox"/>	<input type="checkbox"/>
History of Melanoma: year/site: _____	<input type="checkbox"/>	<input type="checkbox"/>	Any immediate family history of melanoma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear sunscreen? <i>What SPF level:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Do you tan in a tanning salon?	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL AND VACCINATION HISTORY**

1. Are you an active tobacco user? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former	3. Did you have a Pneumonia Vaccination? <input type="checkbox"/> Yes, when _____ (year) <input type="checkbox"/> No
2. How many times in the past year have you had 4 or more alcoholic drinks in one day? <input type="checkbox"/> Never <input type="checkbox"/> No alcohol use <input type="checkbox"/> 1-2 days <input type="checkbox"/> 3 or more days	4. Did you receive an Influenza (aka "flu") shot? <input type="checkbox"/> Yes, when _____ (year) <input type="checkbox"/> No <input type="checkbox"/> Declined
	5. Are you allergic to adhesive? <input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Are You allergic to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE LIST ALL ACTIVE MEDICATIONS BELOW:**

<i>Example: aspirin 81 mg 1/day</i>	

**PLEASE LIST ANY MEDICATION ALLERGIES** \_\_\_\_\_

**PREFERRED PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address/ City/Zip: \_\_\_\_\_  
 Primary Insurance Carrier: \_\_\_\_\_ Name of Insured (Subscriber): \_\_\_\_\_  
 Subscriber DOB: \_\_\_\_\_ Subscriber Gender:  Male  Female 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:



# PARKS DERMATOLOGY

## Notice of Patient Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice is effective March 1, 2013 and applies to all protected health information as defined by federal and state regulations. (Rev. 3/2013)

### Understanding your health record/information:

What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

### Your Health Information Rights:

Although your health record is the physical property of this practice, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this practice

### Our Responsibilities, we are required to:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".

### To Report a Problem

If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

### Treatment, Payment and Health Operations:

**Treatment:** Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment healthcare information to assist them in treating you.

**Payment:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

**Healthcare Operations:** Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information maybe used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

**Business Associates:** There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)

**Communication with family:** Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care as governed by federal/state law.

**Research:** We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers Compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Public health:** As required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Correctional institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

**Law enforcement:** We may use or disclose your PHI as required by law or required by a court ordered subpoena.

**Abuse and Domestic Violence:** As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

**Authorization:** We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.