Westside Dermatology

Chart #____________________

Date____________________

Name of Patient ____
Last Name First Middle/Maiden

Mailing Address ____

____

City State Zip

Home Phone #________________ Cell # ________________ Work #________________

E-Mail Address ____

Date of Birth ____________________Age_________ Male ( ) Female ( )

Single ( ) Married ( ) Widowed ( ) Divorced ( )

Occupation ____________________________ Place of Employment ____________________

Spouse's name ____________________________ Spouse's Employer____________________

Primary Physician ________________________Referred by ____________________________

List all prescription and non-prescription medications you are now taking:

____

____

Pharmacy Name ____________________________**Pharmacy Location** ________________________

Please circle anything that applies to you:

Hepatitis or Liver Disease	Fever Blisters	Bleeding Disorder/ Blood Disease
Epilepsy or nerve Disease	Blood Transfusions	Lung Disease
HIV/AIDS Infection	Stomach or Intestinal Disease	Heart Disease
Thyroid/Hormone Disease	Arthritis/Muscle Disease	Diabetes
High Blood Pressure	Kidney Disease	Major Surgery

Please list any allergies: ____

Please answer the following:

Do you smoke?	______ Yes	______No
Are you pregnant?	______ Yes	______No
Do you have a Pacemaker?	______ Yes	______No
Do you faint easily or bleed freely?	______ Yes	______No
Do you have a history of Skin Cancer?	______ Yes	______No
Has a family member ever had skin cancer?	______ Yes	______No
Have you ever had an allergic reaction to dental? Or local anesthesia? (Novocain, Lidocaine, Xylocaine)	______ Yes	______No
Do you take aspirin or a blood thinner?	______ Yes	______No

What is the reason for today's visit? ____________________________________

How long have you had this problem? ____________________________________

Where is it located? ____

Name of Patient ____
Last Name First Middle/Maiden

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU, AT TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK, AND ALL MAJOR CARDS, VISA, MASTERCARD AND AMERICAN EXPRESS**. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Westside Dermatology to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Westside Dermatology when an assigned claim is filed.

General appointments not cancelled at least 24 hours in advance will be charged a twenty five dollar ($25) fee; Cosmetic, and surgery appointments not cancelled will result in a fifty dollar ($50) charge this will not be covered by your insurance company.

_______________________________________ _______________

Signature of Patient or Legal Guardian Date

Can we leave message at work? _______________ Can we leave a message at home? _____________

Can we discuss your medical condition with a family member? Whom? _________________________

Who do we contact in an emergency? _______________________ Phone # _____________________

WRITTEN ACKNOWLEDGEMENT FORM

RECEIPT OF NOTICE OF PRIVACY PRACTICES

LEAVITT MEDICAL ASSOCIATES OF FLORIDA, INC.

D/B/A ADVANCED DERMATOLOGY AND COSMETIC SURGERY

I, ________________________________, have (1) received a copy Notice of the Privacy Practices of

Patients Name

Advanced Dermatology and Cosmetic Surgery (AD&CS)

or

(2) Been offered a copy of AD&CS Notice of the Privacy Practices but declined to accept a copy.

_______________________________________ _______________

Signature of Patient Date