SUN DERMATOLOGY
MOHS SURGERY | GENERAL | COSMETIC

Name: _____ Date of birth: _____/_____/_____ Age: _____ Sex: M_____ F_____

Mailing Address: _____ Apt #_____ City_____ State____ Zip _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____ Employer Phone: _____

SSN: _____ Race:_____ Ethnic Group: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Physician: _____ Referring Physician: _____

*Primary Insurance:_____ ID Number :_____

Cardholder's Name:_____ Cardholder's SSN:_____

Relationship to Patient:_____ Cardholder's Date of Birth:_____

*Secondary Insurance:_____ ID Number:_____

Cardholder's Name:_____ Cardholder's SSN: _____

Relationship to Patient:_____ Cardholder's DOB: _____/_____/_____

IF THE PATIENT IS UNDER THE AGE OF 18, PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE GUARANTOR:

Guarantor Name: _____ Date of Birth: ___/___/___ Preferred Phone: _____
Address: _____ Relationship to Patient: _____

Have you seen Dr. Sunseri as a patient in the past? **YES** **NO**
How did you hear about Sun Dermatology? _____
When calling with results, is it okay to leave a detailed message? **YES** **NO**

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature_____ **Date** ____/____/_____

I hereby authorize my insurance benefits, including Medicare, to be paid directly to Sun Dermatology. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether they are paid by said insurance. I hereby authorize said assigned to release all information necessary to secure that payment. In the event this account is assigned to collections, I agree to pay all costs of collection including reasonable attorney fees.

PAYMENT POLICY: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered and cosmetic services at the time of service.

PLEASE BE ADVISED: THERE MAY BE ADDITIONAL COSTS FROM AN EXTERNAL LABORATORY IF A BIOPSY OR CULTURE OF ANY KIND IS PERFORMED.

Patient or Responsible Party Signature _____ **Date** ____/____/_____

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Medical Records Release

Please list all persons to whom we may disclose your personal health information:

Name:	Relationship:	Preferred Phone:
_____	_____	____-____-_____
_____	_____	____-____-_____

For access to your records and results via your Patient Portal please provide us with an active email address that we can associate with your Patient Portal. You will receive an email providing you with access upon activation of your account.

Email Address: _____

Medication History Consent

I hereby give permission to Sun Dermatology to request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Name: _____ Date: _____

Pharmacy Information

In the event a prescription is needed please list a preferred pharmacy:

Pharmacy Name: _____

Location: _____

Phone: _____

Cosmetics

Would you like to be notified via e-mail or phone about cosmetic events and specials? If so, please fill in the information below:

Email Address:_____ Contact Number: _____

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Patient Consent for Medical Photography

Please check one or all that apply

Patient Name _____

☐ I consent to the use of my photographs for my medical records **ONLY (required for treatment by Sun Dermatology)**

☐ I consent for my photographs to be used for academic purposes that include but not limited to medical publications, electronic publications, teaching purposes and my medical records. I understand the images may be seen by the general public, in addition to scientists and medical researchers. I understand that although these images will be used without identifying information such as name, it is still possible that someone may recognize me.

☐ I consent for my photographs to be used in cosmetic purposes that include but not limited to before and after examples, cosmetic social media marketing, and general cosmetic marketing.

☐ Check here if minor or unable to provide consent.
I consent for medical photographs to be made of my child (or the person that I am a legal guardian to/Durable Power of Attorney

Patient Signature_____ **Date**____/____/_____

APPOINTMENT CANCELLATION POLICY AGREEMENT

Sun Dermatology is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.
PLEASE call us at (850) 215-3612, 24 hours before your scheduled appointment to notify us of any changes or cancellations. **To cancel a Monday appointment, please call our office by 11:00 P.M. on Friday.** If prior notification is not given, you will be charged $30 for the missed appointment.

****For Cosmetic appointments (60 minutes or longer) --- A deposit of $350 is required at the time of scheduling your appointment. This deposit reserves your time with the provider and will be credited towards any services rendered.**

By signing below, I consent to the above terms.

Patient Signature_____ **Date**____/____/_____

Patient's Parent/Guardian if under 18_____**Date**____/____/_____

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Name_____

Medical History – check all that apply
o Anxiety
o Arthritis
o Asthma
o Atrial fibrillation
o COPD
o Coronary arteriosclerosis
o Depression
o Diabetes
o Hypertension
o GERD
o Hearing loss
o HIV/AIDS
o Hyperthyroidism or hypothyroidism
o Cancer: _____

Surgical History – check all that apply
o Appendectomy
o Coronary artery bypass
o Delivery by C -Section
o Gallbladder removal
o Heart valve replacement
o Hysterectomy
o Hip joint replacement:
Left Right Both
o Knee joint replacement:
Left Right Both
o Kidney transplant
o Liver transplant
o Mastectomy
o Tubal ligation

Other Medical History:
_____

Skin Disease History – check all that apply
o Acne
o Actinic keratosis
o Basal cell skin cancer
o Dysplastic nevus
o Eczema
o Melanoma
o Flaking/Itchy scalp
o Psoriasis
o Squamous cell skin cancer

Social History:
Smoking Status:
o Never smoker
o Former smoker
o Current smoker
Alcohol Consumption:
o None
o Less than 1 drink per day
o 1-2 drinks per day
o 3 or more drinks per day

Do you wear sunscreen? **Yes or No** if yes, what SPF? ____
Do you tan in a tanning salon? **Yes or No**
Do you have a family history of Melanoma? **Yes or No** If yes which relative? _____

Please list any current medications (i.e., Aspirin 81 mg once daily)
_____
_____

Allergies: _____

What brings you in today?
_____

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Vaccination Status

Have you received your pneumonia vaccine? Yes or No

Have you received your flu vaccine? Yes or No

Advanced Directives

Advanced Directives are designed to respect your wishes about life-saving medical treatment if you are unconscious or incapacitated. Select one or more of the following options:

_____ **Full Cardiopulmonary Resuscitation:** I want full Cardiopulmonary Resuscitation (CPR) efforts to be made (Full Code)

_____ **Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an external defibrillator to restart my heart, even if it is necessary to save my life.

_____ **Do Not Intubate:** I do not wish to have a breathing tube inserted, even if it is necessary to save my life.

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes or No

Proxy's Name: _____

Proxy's Phone Number: _____

Do you have a living will? Yes or No

Patient Signature: _____ Date: ___/____/_____

Parent/Guardian signature if patient under 18 yrs of age: _____ Date____/____/_____