



Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: FEMALE MALE

Phone Number (CELL): _____ Phone Number (HOME): _____

Preferred phone: ___ Cell ___ Home Marital Status: Married Single Divorced Widowed

PERMISSION TO LEAVE A DETAILED MESSAGE: YES OR NO

Email Address: _____

Emergency Contact: NAME _____ PHONE# _____

Language: ___ ENGLISH ___ SPANISH ___ OTHER ___ Race: WHITE ___ SPANISH ___ OTHER _____

Ethnic Group: WHITE _____ AFRICAN AMERICAN _____ HISPANIC _____ ASIAN _____ DECLINED _____

Primary Care Physician: _____ Phone# _____

Referring Physician: _____ Phone# _____

Preferred Pharmacy

Name: _____ Phone Number: _____

City or Zip Code: _____ PERMISSION TO ACCESS OUR PHARMACY MEDICATION RECORDS? YES OR NO

The Following insurance plans are accepted at this office.

Present your insurance card along with your driver's license so we may make a copy for your file.

Medicare ___ Blue Cross/Blue Shield Traditional, PPO and PPC and Health Options ___ United Health Care ___
Baycare ___ Aetna ___ Cigna ___ Humana ___ Avmed ___

Insured Name and Date of birth _____ relationship to insured _____

Permission is hereby granted to John Millns, M.D., PA, dba Dermatology Associates of Tampa Bay to render such medical and/or surgical treatment only after it has been discussed and deemed necessary and to release any information via fax or other method including Payment, Treatment or Health Care Operations per HIPAA guidelines. I understand I am responsible for all services rendered, insurance co-payments, coinsurance and deductibles. If my account becomes overdue and I understand that my account may be turned over to a collection agency.

Signature: _____ Date: _____

MEDICARE PATIENTS MUST SIGN THE TWO AUTHORIZATIONS BELOW.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Dermatology Associates of Tampa Bay. Regulations pertaining to Medicare assignments of benefits apply.

Signature as it appears on Medicare Card: _____ Date: _____

I authorize Medigap (secondary insurance) benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap (secondary) carrier any information needed to determine these benefits payable for related services

Signature as it appears on Medigap (secondary) card: _____ Date: _____

Your personal information will not be shared with a third party except as authorized by you or by law. With your permission, we will send you appointment reminders as well as keep you up-to-date on the latest medical trends, new products and information regarding the practice.

PATIENT NOTICE OF PRIVACY PRACTICES AND COMMUNICATIONS

John L Millns, MD, PA dba Dermatology Associates of Tampa Bay will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire Private Policy Notices is posted in the waiting room as well as at www.dermassociatesoftb.com.

From time to time, we may need to contact you or discuss your medical information with your family or someone else of your choosing. The information shared will be the minimum necessary based on the professional opinion of the healthcare provider.

For lab results and other information communicated to you by phone, you will be contacted by one of our nurses.

1. With whom may we speak regarding your health (e.g., spouse, child, parent, etc.)?

Name	Phone No.	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. May we call you, and if necessary, leave a message on your answering machine or voice mail regarding:

Purpose	Call You		Leave a Message	
	Yes	No	Yes	No
Results	_____	_____	_____	_____
Your health	_____	_____	_____	_____
Upcoming appointment(s)	_____	_____	_____	_____
Billing matters, including that a charge in excess of \$50.00 will be posted to your card	_____	_____	_____	_____
Information regarding the practice	_____	_____	_____	_____

3. May we send you e-mail regarding:* Email Address: _____

Purpose	Yes	No
Latest medical trends, new products, and information regarding the practice	_____	_____

* We do not send medical or otherwise confidential information to you via e-mail. We use a third-party tool (e.g., Constant Contact) to provide these e-mail updates to you. You may opt-out of receiving these updates at any time.

You may choose, from time to time, to e-mail us information using regular e-mail. While e-mail is convenient, it does pose several risks. Please see the "Important Notice About E-mail Communications" notice for details.

RECEIPT of NOTICE OF PRIVACY PRACTICES and NOTICE ABOUT E-MAIL COMMUNICATIONS:

My signature below indicates that I have received a copy of my physician's "Notice of Privacy Practices" and "Important Notice About E-mail Communications."

Signature of Patient / Legally Authorized Representative Printed Name Date

Relationship to Patient: Parent Spouse Next-of-Kin Legal Guardian Power of Attorney



In our efforts to go green and keep the cost of healthcare down we have implemented the following financial policy to cover incidentals. Our policy is very similar to a hotel check-in procedure.

If we are providers for your insurance company, you will be asked for a credit card number at the time you check in. The information will be held in Pay Junction's (our service provider) vault until your insurance has paid their portion and/or notified us of your financial responsibility. At that time, any remaining balance due to Dermatology Associates of Tampa Bay will be charged to your credit card.

If we are NOT providers for your insurance plan OR you do not wish to participate in our financial policy, you will be required to pay in full at the time of your visit. We will file your medical claim to your insurance company. If after receiving your Explanation of Benefits (EOB) from the insurance company if it reflects any payment, credits will then be refunded to you.

It is in your best interest to understand your insurance plan.

This credit card policy will be an advantage to you as you will no longer have to prepare and mail us checks. This policy benefits everybody by keeping the cost of healthcare down, and by allowing us to concentrate first and foremost on your medical needs.

We care about the security of your credit card information. We take a number of steps to protect your credit card information. Once entered into Pay Junction (our service provider) the information is encrypted and only shows our staff the last four digits of the card. Staff members also black out the number on this form leaving only the last four digits. Some patients prefer to have the staff scan their card at the time of service instead of writing the whole number below. If you prefer, just notate the last four digits and the receptionist will scan your card. The security of our system is monitored 24 hours a day by Zymphony Technology Solutions. We also utilize the Barracuda Firewall.

Our credit card on account policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays, Co-insurances, and deductible amounts will, of course, still be due at the time of your visit.

Please note; you will receive a courtesy call to advise any charges that will be posted in excess of \$50.00. Insurance companies normally take 2-3 weeks to process claims.

If you have any questions, please do not hesitate to ask.

I authorize John L Millns, MD, PA dba Dermatology Associates of Tampa Bay to charge outstanding balances on my account to the following credit card. If the billing address for this credit card differs from your home address, please advise the billing address. Thank you.

Visa ___ MC ___ AmEx ___ Discover ___

Account Number _____ Exp Date ____/____

3 digit security Code _____ Zip Code affiliated with card _____

Name on Card (Print) _____

Patient Name _____ Date of Birth _____

Signature _____ Date _____

DATE: _____

PATIENT NAME: _____ DOB: _____

PAST MEDICAL HISTORY (Please check all that apply to you)

- | | |
|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension (High Blood Pressure) |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> Hypercholesterolemia (High cholesterol) |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> BPH (Enlarged prostate) | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> GERD (Acid Reflux) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> NONE of the Above |

PAST SURGICAL HISTORY (Please check all that apply to you)

- | | |
|---|--|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Biopsy |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Kidney Removed: |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Right |
| <input type="checkbox"/> Lumpectomy: | <input type="checkbox"/> Left |
| <input type="checkbox"/> Right | <input type="checkbox"/> Both |
| <input type="checkbox"/> Left | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Both | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Mastectomy: | <input type="checkbox"/> Liver Transplant |
| <input type="checkbox"/> Right | <input type="checkbox"/> Ovaries Removed: |
| <input type="checkbox"/> Left | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Both | <input type="checkbox"/> Ovarian Cyst |
| <input type="checkbox"/> Colon Removed for: | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Pancreas Removed |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> IBD (Inflammatory Bowel Disease) | <input type="checkbox"/> Prostate: Biopsy |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Prostate: TURP |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Hysterectomy: |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> Joint Replacement, Knee: | <input type="checkbox"/> Skin Cancer Surgery: |
| <input type="checkbox"/> Right | <input type="checkbox"/> Not sure of type |
| <input type="checkbox"/> Left | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Both | <input type="checkbox"/> Basal Cell Carcinoma |

Joint Replacement, Hip:

Right

Left

Both

Other Type:

NONE of the above

SKIN DISEASE HISTORY (please check all that apply to you)

Acne

Actinic Keratosis (Precancerous skin growths)

Asthma

Basal Cell Carcinoma

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Melanoma

Poison Ivy

Precancerous Moles (usually called atypical nevi or dysplastic nevi)

Psoriasis

Squamous Cell Carcinoma

Squamous Cell Carcinoma in situ

Other Kind of Skin Cancer

Skin Cancer but not sure what kind

Other Skin Disease or Condition

NONE of the above

CURRENT MEDICATIONS

Please list all current prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary or nutritional supplements.)

***** If you brought a list of medications with you, we can use your list. *****

How do you take it? (by mouth, patch, injection)

Name	Dosage	How often	How do you take it? (by mouth, patch, injection)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES (Please list all medication allergies)

Are you allergic or sensitive to: Adhesive Yes No

Lidocaine Yes No

Epinephrine Yes No

Latex Yes No

Any other types of allergies? _____

SOCIAL HISTORY

Do you smoke? Never Former Smoker Less than daily Daily

Do you drink Alcohol? Never Less than 1 daily 1-2 daily 3+ daily

FAMILY HISTORY

Has anyone in your family ever had? (Please check, if applicable)

Melanoma Yes No

If so, was it your biological Mother, Father, Sister, Brother, Son, Daughter, Aunt,
 Uncle, Nephew, Niece, Grandmother, Grandfather, Grandson, Granddaughter

Any other kind of skin cancer? Yes No **Pre-cancer?** Yes No

Asthma, Hay Fever, Eczema, Psoriasis, Diabetes, Thyroid Disease, Arthritis, Lupus,
 any other Skin Disease? (**Please check all that apply**)

Thank you for filling out this form

***** NOTE *****

We remind patients about future appointments by phone, email, and text.

Please discuss other contact preferences with the office reception.