Mid Florida DERMATOLOGY & PLASTIC SURGERY

Patient Registration

Complete on screen, then print and sign where indicated

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI | PREFERRED NAME

DATE OF BIRTH | AGE | SEX | MARITAL STATUS

SOCIAL SECURITY NUMBER | EMAIL ADDRESS

STREET ADDRESS

CITY | STATE | ZIP CODE

CELL PHONE | HOME PHONE | WORK PHONE

EMPLOYER

REFERRING PROVIDER | PRIMARY CARE PROVIDER

RESPONSIBLE PARTY

Complete only if the patient is a minor or if someone other than the patient is financially responsible.

LAST NAME | FIRST NAME | MI | RELATIONSHIP TO PATIENT

DATE OF BIRTH | SOCIAL SECURITY NUMBER | CELL PHONE

STREET ADDRESS

CITY | STATE | ZIP CODE

EMPLOYER | WORK PHONE

PREFERRED PHARMACY

All prescriptions are sent electronically. Please give us the one pharmacy you want us to use.

PHARMACY NAME | PHARMACY PHONE

PHARMACY STREET ADDRESS

CITY | STATE | ZIP CODE

Mid Florida DERMATOLOGY & PLASTIC SURGERY

Insurance & Authorization

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

INSURANCE INFORMATION

Please present your insurance card and photo ID at check-in.

Primary Insurance

INSURANCE COMPANY | INSURANCE PHONE

MEMBER / POLICY ID | GROUP NUMBER | COPAY AMOUNT

SUBSCRIBER / POLICY OWNER NAME | SUBSCRIBER DATE OF BIRTH

PATIENT RELATIONSHIP TO SUBSCRIBER | EFFECTIVE DATE

Secondary Insurance (if applicable)

INSURANCE COMPANY | INSURANCE PHONE

MEMBER / POLICY ID | GROUP NUMBER | COPAY AMOUNT

SUBSCRIBER / POLICY OWNER NAME | SUBSCRIBER DATE OF BIRTH

PATIENT RELATIONSHIP TO SUBSCRIBER | EFFECTIVE DATE

IN CASE OF EMERGENCY, PERSON TO CONTACT

NAME | RELATIONSHIP TO PATIENT

CELL PHONE | HOME PHONE

AUTHORIZATION & FINANCIAL RESPONSIBILITY

I authorize Mid Florida Dermatology & Plastic Surgery to release medical information to my primary care or referring physician, to consultants when needed, and as necessary to process insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits directly to Michael M. Gutierrez, M.D., P.A.

I request the professional services of Mid Florida Dermatology & Plastic Surgery and accept financial responsibility for those services. Payment is due at the time services are rendered, including any copayment, coinsurance or deductible. We accept cash, check and credit card.

My signature below confirms that I have read and agree to the above.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY | DATE

Physician Extender Acknowledgement

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

OUR PHYSICIAN ASSISTANTS & NURSE PRACTITIONERS

You are currently scheduled to be seen by one of the physician assistants or nurse practitioners below. Each works under the supervision of one of our board certified physicians.

Rebekah Belkin, PA
Sydney Byers, PA
Grace Davis, NP
Jennifer Dembowski, NP
Elisa Endicott, PA
Courtney Frazier, ARNP-C
Brent Hopson, PA-C
Michelle Horta, NP
Shannon Keegan, NP
Darya Kyrylina, NP
Deborah LeBlanc, PA-C, MMS
Taylor Montgomery, NP
Meghan Murray, NP
Jessica Navarro, NP
Ellie Orlando, FNP-C
Angela Pieronowski, NP
Haleigh Ratliff, NP
Rachel Reid, PA-C
Xana Rette, NP
Caitlyn Rhoades, NP
Kelsey Roberts, NP
Sofia Terry, NP
Caitlin Uddo, NP
Karen Vejano, PA
Jessica Wong, NP
Sara Zinn, NP

ACKNOWLEDGEMENT

Please initial, then sign below.

☐ I understand that I may be seen and treated by a physician assistant or nurse practitioner for my dermatologic condition, and I agree to this.

INITIALS

If you would prefer to be seen by a physician instead, just let the front desk know and we will reschedule you. No signature is needed for that.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY | PRINTED NAME | DATE

Mid Florida DERMATOLOGY & PLASTIC SURGERY

Medical History & Allergies

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

Check all that apply.

LUNGS

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic bronchitis
- ☐ Emphysema
- ☐ Morning cough

HEART & CIRCULATION

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Chest pain
- ☐ Prior heart attack
- ☐ Functional heart murmur
- ☐ Rhythm disorder
- ☐ Thrombophlebitis
- ☐ Blood transfusion

OTHER SYSTEMIC

- ☐ Cancer other than skin (type and when)
- ☐ Diabetes mellitus
- ☐ Hay fever
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Renal (kidney) disorder
- ☐ Bladder disorder
- ☐ Liver, stomach or bowel disease
- ☐ Hepatitis (type)
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Epilepsy (seizure)
- ☐ Convulsive disorder
- ☐ Fainting or loss of consciousness
- ☐ Headaches

DO YOU HAVE ANY OF THE FOLLOWING?

- ☐ Mitral valve prolapse
- ☐ Joint replacement
- ☐ Pacemaker or defibrillator
- ☐ Organ transplant
- ☐ Heart defect
- ☐ Artificial heart valve

OTHER MEDICAL HISTORY, SURGERIES OR HOSPITALIZATIONS

ALLERGIES

List all drug, food and other allergies, and what reaction each one causes. If you have none, write NONE.

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Medications & Social History

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Include prescriptions, over-the-counter medicines, vitamins and supplements. If you take none, write NONE on the first line.

MEDICATION	STRENGTH / DOSE	HOW OFTEN YOU TAKE IT

If you need more room, continue on the back of this page.

SOCIAL HISTORY

DO YOU DRINK ALCOHOL?

IF YES, HOW MANY DRINKS PER DAY?

DO YOU SMOKE OR VAPE?

IF YES, WHAT AND HOW OFTEN?

DO YOU USE RECREATIONAL DRUGS?

IF YES, WHAT TYPE AND HOW OFTEN?

OCCUPATION OR TYPE OF WORK

WHAT ARE YOUR HOBBIES?

REGULAR CONTACT WITH CHEMICALS, PLANTS OR OTHER IRRITANTS AT WORK OR HOME?

IF YES, WHAT?

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Skin History

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

SKIN HISTORY

HAVE YOU EVER HAD SKIN CANCER?

IF YES, WHAT TYPE AND WHEN?

HAS ANYONE IN YOUR FAMILY HAD SKIN CANCER?

IF YES, WHO AND WHAT TYPE?

HAS A BLOOD RELATIVE EVER HAD MELANOMA?

IF YES, WHO AND HOW ARE YOU RELATED?

DO YOU HAVE A HISTORY OF ANY SPECIFIC SKIN DISEASE?

HAVE YOU HAD SURGERY IN THE LAST 6 MONTHS?

IF YES, WHAT TYPE?

DO YOU BLEED EASILY WITH SKIN PROCEDURES?

DO YOU TAKE A BLOOD THINNER? WHICH ONE?

HAVE YOU EVER HAD ANESTHESIA (LIDOCAINE)?

IF YES, HAVE YOU EVER REACTED TO IT?

DO YOU PREMEDICATE WITH ANTIBIOTICS BEFORE PROCEDURES?

IF YES, WHICH ANTIBIOTIC?

HAVE YOU EVER BEEN EXPOSED TO HIV (AIDS)?

DOES ANY CONDITION OR MEDICATION WEAKEN YOUR IMMUNE SYSTEM?

When you are exposed to the sun, does your skin: ☐ Tan only ☐ Tan and burn ☐ Burn only

REASON FOR TODAY'S VISIT

WHAT ARE YOU HERE FOR TODAY?

HOW LONG HAS THIS PROBLEM BEEN PRESENT?

WHAT MAKES IT BETTER OR WORSE?

WHAT OTHER SYMPTOMS HAS THIS PROBLEM CAUSED?

FOR WOMEN

ARE YOU PREGNANT? | IF YES, DUE DATE | PLANNING TO BECOME PREGNANT? | BREASTFEEDING?

Mid Florida DERMATOLOGY & PLASTIC SURGERY

HIPAA Acknowledgement

and designation of personal representatives

I. ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that Mid Florida Dermatology & Plastic Surgery has provided a copy of its Notice of Privacy Practices, and that I have read it or had the opportunity to read it, that my questions about my rights were answered to my satisfaction, and that I agree to its terms.

PRINTED NAME OF PATIENT | SIGNATURE OF PATIENT / PARENT / GUARDIAN | DATE

II. PERSONAL REPRESENTATIVES

I agree that the practice may share health information that is directly relevant to their involvement in my care or payment for my care with the people listed below.

FULL NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

IF THE PATIENT IS A MINOR, NAME OF PARENT OR GUARDIAN SIGNING ON THEIR BEHALF

RELATIONSHIP

If a personal representative is a court appointed legal guardian, a copy of the court documents must be provided for the medical record.

III. HOW WE MAY CONTACT YOU

Under Privacy Rule Section 164.522(b). Check every option you allow.

HOME / CELL PHONE NUMBER

- ☐ May leave a detailed message
- ☐ Leave a call-back number only

WORK PHONE NUMBER

- ☐ May leave a detailed message
- ☐ Leave a call-back number only

MAILING ADDRESS FOR WRITTEN COMMUNICATION

☐ OK to mail to the address above

EMAIL ADDRESS

☐ OK to email me

OTHER INSTRUCTIONS

PRINTED NAME OF PATIENT | SIGNATURE OF PATIENT / PARENT / GUARDIAN | DATE

Office & Financial Policies

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

Thank you for choosing Mid Florida Dermatology & Plastic Surgery for your skin care. We are committed to outstanding medical treatment and care. Because insurance coverage and financial responsibility can be confusing, our policies are outlined below.

INSURANCE

Please have your insurance card available when you check in. Many plans require a referral from your primary care physician before you receive services, so please bring that referral with you. As a courtesy we will verify your coverage and bill your carrier on your behalf. Participating plans require that copays be paid at the time you receive services.

You are responsible for payment of your bill. Your provider may perform procedures or services that are necessary for your health but are not covered by every insurance contract, and you will be responsible for those charges. Questions about your coverage should go to the customer service or member services number on your insurance card. We will send you a statement showing what your insurance paid, and any remaining balance is due when you receive that statement. Please tell us about any change to your insurance or your demographic information.

If you cannot pay a balance in full, please call our billing department at (407) 299-7333, extension 1330, to arrange a payment plan. Coinsurance and deductibles cannot be waived by our practice. You may also receive separate bills from a participating laboratory or from the Mid Florida Dermatology & Plastic Surgery on-site laboratory.

NO INSURANCE OR SELF PAY

Payment is due on the day services are rendered. A price list for certain services is available on request before those services are performed.

RETURNED CHECKS

A $25.00 charge will be added to your account for any check returned by your bank for any reason.

APPOINTMENT CANCELLATIONS

If you cannot keep a scheduled appointment, please call our office at least 24 business hours in advance to reschedule so we can offer your time to another patient. Failure to do so will result in a $50.00 fee added to your account.

MEDICAL RECORDS

We will provide a copy of your medical records on request. You will need to sign a release. Please allow 10 business days for copying. The fee is $1.00 per page for the first 25 pages and 25 cents per page after that, and payment is due when you receive the records.

My signature below confirms that I have read and understand these policies.

SIGNATURE OF PATIENT / GUARDIAN | PRINTED NAME | DATE