Ashraf M. Hassanein, M.D., Ph.D.
Board Certified Dermatologist (AAPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

Sandra Lopez, PA-C
Rosy Singleton, PA-C
Shelly Hansel, PA-C
Board Certified Physician Assistants

General Information DATE:_____

Name _____Age_____Date of Birth ____/____/____
Last First M.I.

SS#_____-_____-_____ Sex: M F Primary Care Physician: _____

Mailing Address:

_____
City State Zip

Phone: Home (____) _____-_____Work (____)_____-_____ Cell (____)_____-_____

Do you have an alternate address? Yes No; **if yes, please print here:**

_____

Would you like to receive emails for notice of upcoming events? ☐ Yes ☐ No

Email: _____

Marital Status: (circle one) Single Married Divorced Widowed Separated

Employment Status: (circle one) Full-time Part-time Retired Other: _____

Spouse/Parent Name (If Applicable): Last _____ First _____

DOB _____ Age _____

RESPONSIBLE PARTY (if different from patient)

Name of Insured _____Relationship to patient:_____

SS#_____-____-_____ Date of Birth (of insured) ____/____/_____

Mailing Address: _____

Phone: Home (____)_____-_____ Work (____)_____-_____ Cell (____)_____-_____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____ Policy Holder's Name_____

SS #_____ Birthdate: ____/____/_____

Group #_____ Contract # _____

**** Secondary Insurance information.**

Secondary Insurance Name _____

Policy Holder's Name_____

SS #_____ Birthdate: ____/____/_____

Group #_____ Contract # _____

In case of Emergency, who should be notified (other than those already listed above)?

Name _____Phone _____ Relationship _____

Name _____Phone _____Relationship_____

How were you referred to the office? Friend Family Advertisement Other_____

Referring Physician _____**Phone** _____

All of the above is correct to the best of my knowledge, and I agree to notify this office of any changes in a timely manner.

Patient or Responsible Party Signature _____ **Date** ____/____/20____

Financial Responsibility Agreement

I have been informed and understand that I am financially responsible for payment of services at the time of the visit l also understand that all laboratory charges are billed separately from the physician and are my responsibility to pay.
In the event, that my doctor deems any procedure medically necessary for my treatments, but the cost is not covered by my health insurance, I agree to assume full financial responsibility for payment.

Signed: _____**Date:**_____

Assignment of benefits

I, the undersigned, hereby authorize the above named medical group to release to my insurance company any medical information acquired to assist in processing any health insurance and /or medical claims for services received from my doctor. I authorize payment of such claims to be permanently assigned to Florida Dermatologic Surgery & Aesthetics Institute. I also understand that I am financially responsible for all charges whether or not paid by the said insurance company.

Signed: _____**Date:**_____

Informed Consent:

I understand that during my course of treatment, unforeseen conditions may occur that necessitates a skin biopsy(s) to be taken by shave, punch, and / or excision. In addition, I also give permission to have minor surgical procedures and any subsequent treatment as deemed necessary as long as the risk and complications are discussed with me prior to the said procedure. These risks include, but are not limited to, scarring, bleeding, swelling, pain, deformity, infection, and/ or ulceration. I will also inform the dermatologic practitioner of any possible contraindications to the planned procedure, including medications, such as anticoagulants, aspirin, cardiac, infectious or psychotropic.

I recognize that every surgical procedure involves uncertainty and no result can be guaranteed. I also recognize that the practitioner is not responsible for natural complications that may occur. If any postoperative complications occur, it is my responsibility to contact the practitioner as soon as possible.

I also consent the disposal of any tissue, which is removed in accordance with accustomed practice and procedure. I give my permission to have any tissue removed during the procedure sent for histologic examination.

I understand that any controversy or claim arising out of medical care provided will be resolved through mandatory binding arbitration under the rules of the Florida arbitration code.

Signed: _____ **Date:** _____

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ Yes_____ No_____

Other: _____ Yes_____ No_____

Other: _____ Yes_____ No_____

PATIENT MUST COMPLETE

A. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.
I allow the following form of communication: (Check the following that apply)

☐ Telephone: _____ Detailed message ____ Call back number only ____
_____ Detailed message ____ Call back number only ____
☐ Written correspondence: Mailed to home address _____ Email _____

PRINTED NAME: _____
PATIENT/Parent/Guardian Signature: _____

Date: _____

Medical History

Patient Name: _____ Age:_____ Date of Birth:_____
Date forms completed:_____
Reason for Visit:_____
Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Past Medical History: (circle all that apply)

Depression	ADD/ADHD	Anxiety	Seasonal allergies
Thyroid abnormalities	High Blood Pressure	Lung disease	Liver disease/Hepatitis
Developmental Abnormalities	Kidney Disease	HIV/AIDS	Diabetes
Cancer (**detail below**)	Arthritis	Heart Disease	Headaches
Strokes	Seizures	Angina	Heart attack
Mitral valve prolapse	Heart Valve	Bypass	Stents
COPD	Emphysema	Bronchitis	Asthma
TB	Prostate	Anemia	Bleed or bruise easy
Communicable diseases	GI Issues	Paralysis	Hip/Knee Replacement
Congestive Heart Failure	Pacemaker	Depression	

Other medical conditions:

_____
_____

Comments:_____

Past Skin History: (circle all that apply)

Acne	Actinic keratosis	Atypical/Dysplastic moles
Basal Cell Carcinoma	Squamous Cell Carcinoma	Melanoma
Eczema/Atopic Dermatitis	Psoriasis	Other skin cancer _____
Rosacea	Allergic Contact Dermatitis	Hair Loss
Warts	Molluscum	Shingles
Other (detail below)	Fever Sores	Rashes

Comments: _____
_____

Sunscreen Use: □ Daily □ Sometimes if Sunny □ Always if Sunny □ Rarely/Never

Current Sun Exposure: □Very little □ Moderate □ A lot
Past Sun Exposure: □Very little □ Moderate □ A lot

Current skin care regimen:

_____
_____
_____

Females: (circle all that apply)
Pregnant Nursing Planning children in the next 6 months
Tubal Ligation Hysterectomy Uterine Ablation
Method(s) of birth control:

List all medications (including topical, over-the-counter, and supplements):

_____

_____

_____

Blood Thinners: _____

Allergies: _____

_____

Medication Sensitivites: _____

_____

List all past surgeries/accidents/illnesses (include approximate dates):

_____

_____

_____

<u>Family History (first degree relatives only):</u> (circle all that apply)

Unknown	Adopted	
Depression	Seasonal allergies	Diabetes
Thyroid disease	Autoimmune Disease	Lupus
Acne	Actinic keratosis	Atypical/Dysplastic moles
Basal Cell Carcinoma	Squamous Cell Carcinoma	Melanoma
Eczema/Atopic Dermatitis	Psoriasis	Other skin cancer _____
Rosacea	Allergic Contact Dermatitis	Hair Loss
Warts	Molluscum	Other (detail below)

Cancer: _____

Other medical conditions:

_____

_____

_____

Comments: _____

Living arrangement (alone, with family, with roommates, nursing home, etc): _____

_____

Smoking: □ Never □ Occasionally □Daily

Alcohol: □ Never □ Social/Occasional □Daily

Recreation Drug Use: _____

Review of Systems: (check any symptoms that you have experienced in the last month)

□ **No to all of the below**

□fatigue	□chest pain	□swelling of feet, ankles, hands
□fever/chills	□headache	□hormone problem
□frequent diarrhea	□nausea/vomiting	□excessive thirst/urination
□blood in urine	□kidney stones	□slow to heal
□anemia	□bruise/bleed easily	□past transfusion
□joint pain/weakness	□thinning hair	□sun sensitivity
□nail changes	□dry skin	□rash/itching
□memory loss	□cough	□sleep problems
□asthma	□shortness of breath	□suicidal thoughts

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of **Florida Dermatologic Surgery & Aesthetics Institute, P.A.,** I hereby acknowledge receipt of this facility's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of this facility's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐Parent ☐Legal Guardian

Signature: _____

Date: _____