WATERSIDE DERMATOLOGY

New Patient Questionnaire

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill in All Fields)

Patient's Name _____
Last First Middle

Nick Name _____ Age _____ Date of Birth _____

Primary Address _____
Street & Apt # City State Zip

Secondary Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

E-mail Address _____ Social Security Number _____

Gender ____ Race _____ Marital Status: ☐ Single ☐ Married to: _____ ☐ Other: _____

Emergency Contact _____

Relationship to Patient _____ Phone # _____

How did you hear about us?

☐ Newspaper Ad ☐ Word of Mouth ☐ Referred by Waterside Patient ☐ Other _____

I understand that office visit charges are payable on the day service is rendered. I authorize Waterside Dermatology to bill my insurance company. Regardless of my insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Waterside Dermatology and myself.

Signature _____ **Date** _____

WATERSIDE DERMATOLOGY

Waterside Dermatology, PLLC
300 Riverside Dr E Suite 2200
Bradenton FL, 34208
Phone: 941-748-3376
Fax: 941-748-7562
watersidederm.com

General Consent Form for Dermatology Services

Patient Name: _____

Date of Birth: _____

I, the undersigned patient or legal guardian of the patient, voluntarily provide my consent to receive dermatology services from Waterside Dermatology. The services may include but are not limited to: skin examinations, diagnosis and treatment of skin conditions, procedures (e.g. biopsies, cryotherapy, electrodessication and curettage, surgical procedures), prescriptions for medications, and cosmetic dermatology services.

I understand that biopsies are meant for diagnostic purposes and are not considered a treatment. Risks of biopsies include bleeding, infection, redness/swelling at site, scar and pain. I understand that cryotherapy may be used to treat benign, pre-malignant, and malignant skin lesions. Risks of cryotherapy include pain, recurrence, redness/swelling at site, blistering, scar, infection and skin discoloration.

I understand the purpose of the dermatology services is to assess, diagnose, and provide treatment or management for skin-related conditions.

I acknowledge that my health information will be kept confidential, and any data collected during the course of dermatology services will be handled in accordance with applicable privacy laws.

I understand that photographs or other records may be taken for the purpose of documenting my condition and treatment progress. These records will be kept confidential and may be used for medical and educational purposes.

I have been informed of my rights as a patient, including the right to information, privacy, and the right to refuse treatment. I understand my responsibilities as a patient, including providing accurate health information.

I voluntarily consent to receive dermatology services from Waterside Dermatology. I understand the information provided in this consent form and agree to the terms outlined.

_____

Patient/Agent/Guardian Signature Date

WATERSIDE
DERMATOLOGY

Notice of Privacy Practices

USES AND DISCLOSURES

1. During your course of treatment, it will be necessary for our practice to share your medical information in the following examples
    - Laboratory Procedures: In order to correctly identify any specimens that we forward to the laboratory, we will need to include your medical information on the laboratory request form.
    - Physician Referral: If we determine that you should be treated by another physician in a different specialty, we will need to forward your medical information to that physician's office
    - Billing & Collections: In order for our practice to receive payment from your insurance company, we will need to share your medical information with your carrier.
2. On a much less frequent basis, our practice may be required to disclose confidential information with your written consent for the following legal reasons:
    - Uses and disclosures for the public health activities
    - Reporting about victims of abuse, neglect, or domestic violence
    - Disclosures for health oversight activities
    - Disclosures for judicial and administrative proceedings
    - Disclosures for law enforcement purposes
    - Uses and disclosures about decedents
    - Disclosures to avert a serious threat to health or safety
    - Uses and disclosures for specialized government functions
3. Any other uses and disclosures of your health information will require your individual written authorization which you may revoke such authorization.
4. On occasion, our employees may contact you at home to provide appointment reminders or information about your treatment.

PATIENT RIGHTS

1. The right to request restrictions on certain uses and disclosures, including a statement that the practice is not required to agree to a requested restriction
2. The right to receive confidential communications
3. The right to inspect and copy protected health information
4. Right to amend protected health information
5. The right to receive an accounting of disclosures of protected health information
6. The right of an individual to obtain a paper copy of this notice from the practice upon request

MEDICAL PRACTICE DUTIES

1. Our practice is required by law to maintain the privacy of confidential information and to provide our patients with notice of its legal duties and privacy practices with respect to such information
2. Our practice is required to abide by the terms of the notice currently in effect
3. Our practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all confidential information that it maintains. Any revisions to our Privacy Practice Policy will be noted in this Notice within effective date of such change.

PRIVACY OFFER

Our Office Manager is the dedicated Privacy Officer and can be contacted at: (941) 748-3376

300 Riverside Drive E Suite 2200, Bradenton, FL, 34208

Phone: 941-748-3376 Fax: 941-748-7562 www.watersidederm.com

WATERSIDE
DERMATOLOGY

PATIENT PRIVACY PREFERENCES:

Please indicate the family member(s) or other person(s), if any, with whom we may discuss your general medical information (i.e. diagnosis, treatments, payments, etc.).

Relative's name	Phone number
_____	_____
_____	_____

Can confidential messages (i.e. appointment reminders, lab and pathology results, or other health information) be left on your telephone answering machine or voicemail?

Please circle one: YES NO

By signing below, I have read, understand, and agree to the above privacy practices, policies, and preferences:

Patient/Guardian Signature _____

Date _____

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WATERSIDE DERMATOLOGY

Intake and History Form

Name _____ DOB: _____

PAST MEDICAL HISTORY

Select any of the following medical conditions you currently have:

- ☐ Alzheimer's/Dementia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostate Hypertrophy
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Reflux)
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism (high)
- ☐ Hypothyroidism (low)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____
_____
_____
_____
_____

PAST SURGICAL HISTORY

Please list any major surgeries you have had in the past *3 years*

_____

_____

_____

SKIN DISEASE HISTORY

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Dry Skin
- ☐ Eczema
- ☐ NONE
- ☐ Other

_____
_____
_____
_____
_____

Do you have a family history of melanoma?

☐ Yes ☐ No

If yes, which relative?

_____

WATERSIDE
DERMATOLOGY

Intake and History Form

PRIMARY CARE PHYSICIAN: _____ Phone #_____

PHARMACY: _____ Phone # _____

Address: _____

MEDICATIONS

List all current medications:

Medication Name	Dose (i.e. 10mg)	Frequency (i.e. two pills twice a day)

ALLERGIES

List all allergies and reactions of known *or* mark NONE

☐ NONE
☐ _____

SOCIAL HISTORY

Smoking status

☐ Current everyday smoker
☐ Current someday smoker
☐ Former smoker
☐ Never smoker
☐ Unknown if ever smoked

Alcohol Intake (please choose one):

☐ None
☐ 1 or less per day
☐ 1-2 per day
☐ 3 mor more per day

WATERSIDE DERMATOLOGY

Intake and History Form

Review of Systems

Please check yes or no if you CURRENTLY have any of the following:

Symptom	Yes	No
Problems with healing		
Problems with scarring (hypertrophic/keloid)		
Rash		
Problems with bleeding		
Fever or Chills		
Cough		
Allergy to adhesive		
Allergy to Lidocaine		
Artificial heart valves		
Artificial joints in the past 2 years		
Blood Thinners		
Defibrillator		
Pacemaker		
Rapid heartbeat with epinephrine		

Reason for Visit Today

What brings you here today? _____

How long ago did you notice this? _____

Please ***circle*** any of the following that pertain to your concern today:

Itchy Bleeding Changing color Changing size Painful Red

Scaly Looks different Getting worse Getting better

Have you tried treating with any prescription or over-the-counter medications? **YES** **NO**

If so, which ones? _____

Have you received any of the following immunizations?

Influenza vaccine?: **YES** **NO** Pneumonia vaccine?: **YES** **NO**