CENTRAL FLORIDA DERMATOLOGY, ALFREDO E. GONZALEZ, MD, PA

REGISTRATION FORM

(Please Print)

Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? ( )	Home phone no.: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (if applicable): _____

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BCBS ❑ Aetna ❑ HealthChoice ❑ Medicare ❑ Multiplan ❑ BeechStreet ❑ PHCS ❑ Mailhandlers ❑ Coventry ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize Alfredo E. Gonzalez, MD, PA to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information necessary to process a claim and hereby assign benefits payable to Alfredo E. Gonzalez, MD, PA in the event of another health insurance becoming primary over my health insurance. Any services not covered by my insurance will become my responsibility for full payment of services rendered by Alfredo E. Gonzalez, MD, PA.

_____ _____

Patient/Guardian signature *Date*

ALFREDO E. GONZÁLEZ, M.D.
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NAME:_____ **DATE OF BIRTH**_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Other

Hypertension
HIV/AIDS
High cholesterol
Hyperthyroidism
Hypothyroidism
Inflammatory Bowel Disease
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

_____

_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement

Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst

Signature:_____ Date:_____

Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Uterine Cancer Hysterectomy
TURP
Skin Biopsy
Spleen Removed
Testicles Removed: (right, left, both)
Hysterectomy Fibroids
Other:_____
None

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other:

_____
_____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?

_____

Any other family history of skin disorders:

_____

Medications: (Please enter all current medications)

_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Signature:_____ Date:_____

Pharmacy Preference:
Name:_____
Street:_____
Zip code:_____
Telephone number:_____

Social History: (Please circle one on each category)

Cigarette Smoking: Never smoked Quit: former smoker Currently smokes

Alcohol Use: YES NO

Language: English Spanish other_____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Occupation and Workplace_____

Place of Residence_____

Hobbies_____

Signature:_____Date:_____

Review of Systems: Are you currently experiencing any of the following symptoms?

(Please check yes or no for the following symptoms)

Symptom	Yes	No
Abdominal pain		
Anxiety		
Bleeding problems		
Bloody stools		
Bloody urine		
Blurry vision		
Changing mole		
Chest pain		
Cough		
Depression		
Fever or chills		
Headaches		
Hay fever		
Joint aches		

Symptom	Yes	No
Muscle weakness		
Neck stiffness		
Night sweats		
Rash		
Seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional weight loss		
Wheezing		

Signature:_____ Date:_____

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CENTRAL FLORIDA DERMATOLOGY

Financial Policy and Authorization Form

1. AUTHORIZATION/CONSENT FOR TREATMENT: The patient and/or authorized legal guardian, whose signature is affixed below, hereby consent to any medical/surgical treatment which may be deemed advisable by the physician. The intention hereof being to grant authority to administer and perform physical exams, treatment and diagnostic procedures which may now or during the course of patient's care be deemed necessary.

2. RESPONSIBILITY FOR ACCOUNT: The patient is responsible for payment of any and all services rendered. The practice will submit claims to contracted insurances and contracted secondary insurances, but should the amount of payment furnished by the insurance be insufficient to cover the services billed, the patient is responsible for payment of the difference. The patient is responsible for full payment of any services provided if the insurance company rejects the claim as a non covered service. In the event that the patient or the practice are not aware of a charge that is not covered by the insurance, the patient is responsible for payment of the charges once we receive a denial of payment from the insurance carrier. The patient is responsible for payment of all annual deductibles, co-payments, co-insurance payments, and charges for non covered or cosmetic services at the time the services are provided. Insurance verification and quotation of benefits by insurance companies is not guarantee of payment. Your insurance company will only make final decision about coverage, benefits, or denial of payment **AFTER** they receive the claim for services provided. Common reasons for denial of payment include, but are not limited to: your insurance considers your diagnosis a cosmetic problem and not a covered medical illness or disagrees with the medical necessity of services provided. Most insurance companies consider skin tags,"age spots", and benign moles cosmetic issues and do not cover their removal. If the patient would like the physician to remove or treat those lesions payment will be collected at the time services are rendered and an insurance claim will not be submitted as doing so may constitute intention to commit fraud as per Florida Law.

3. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Alfredo E. Gonzalez, M.D., PA of benefits otherwise payable to me for medical services incurred. Any services for which assignment is not accepted or any unpaid balances not covered by insurance policy will be payable by me. If payment is not received from my insurance company within 45 days of the date of treatment, I am aware that I am responsible for the entire balance in full. If the insurance company eventually pays I may be refunded, but only the amount the insurance company paid.

4. POS/HMO PRIOR AUTHORIZATION: It is the responsibility of the patient to obtain prior authorization from the primary care physician before each visit to our practice. I understand that if this is not done, I will be responsible for full payment of services at the time they are rendered. The practice will be happy to assist you in obtaining prior authorization prior to two business days for your appointment date. If authorization is not timely received your appointment will be rescheduled.

5. SEPARATE FEES: Tissue is sent to laboratories for processing and examination by pathologist. The patient and/or the insurance company will be billed fee for services rendered by the pathologist.

I permit a copy of this authorization and assignment to be used in place of the original, which will be on file at the practice office.

Your signature below signifies that you understand our financial policy and assignment of insurance benefits, and your responsibility regarding charges incurred in this practice.

_____ _____

Patient/Legal Guardian Signature Date

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CENTRAL FLORIDA DERMATOLOGY

Notice of Privacy Practices Acknowledgment and Patient Consent for Use and Disclosure of Protected Health Information

I hereby consent to allow Alfredo E. Gonzalez, M.D., PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to and read Alfredo E. Gonzalez, M.D., PA Notice of Privacy Practices for a complete description of such uses and disclosures, prior to signing this consent. I acknowledge that I have received and/or read a copy of Alfredo E. Gonzalez, M.D., PA Notice of Privacy Practices.

Alfredo E. Gonzalez, M.D., PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices is available at our front desk. You may obtain a copy by forwarding a written request to Alfredo E. Gonzalez, M.D., PA at 201 N. Lakemont Ave., Suite 800, Winter Park, FL 32792.

I hereby consent to allow Alfredo E. Gonzalez, M.D., PA to call and/or mail or electronically contact me by fax, text, e-mail and leave a message on voice mail or in person at my home or other designated location in reference to any items that assists the medical practice in carrying out TPO, such as insurance items, patient statements, appointment reminders, laboratory test results, prescriptions, clinical care instructions among others. I authorize the practice to provide PHI to the following person(s):

_____

I have the right to request that Alfredo E. Gonzalez, M.D., PA restrict how it uses or discloses my PHI to carry TPO however, Alfredo E. Gonzalez, M.D., PA is not required to agree to my requested restrictions; but if it does, it is bound by this agreement. I may revoke this consent in writing except to the extent that Alfredo E. Gonzalez, M.D., PA has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Alfredo E. Gonzalez, M.D., PA may decline to provide treatment to me. In signing this consent I also affirm that I am legally competent to make decisions about my care.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Patient's name (print) Legal Guardian's name (print)