For Sebring Patients:

If your appointment is with:
Michael J. Rogers, M.D.
go to door **727** US Hwy 27 South; Sebring, FL 33870

If your appointment is with:
Barbara A. Ross, ARNP-C
or
Bobbi J. Hintz, ARNP-C
go to door **723** US Hwy 27 South; Sebring, FL 33870

727 US Hwy 27 South
Sebring, FL 33870
(863) 385-7183

400 Avenue K SE Ste. 3
Winter Haven, FL 33880
(863) 293-7546

Patient Information

Date_____ Soc.Sec. #_____Birthdate_____

Name_____
Last Name First Name Middle Initial

Home Phone_____Cell Phone_____

Mailing Address_____City, State, Zip_____

2nd Address_____City, State, Zip_____

Employer_____Work Phone_____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

Preferred Language:_____ Race:_____ Ethnic Group: Hispanic ☐ Y ☐ N

Pharmacy Information (This will be the pharmacy where all of your prescriptions will be sent)

Pharmacy Name_____

Location_____Phone Number_____

Insurance Information (Please Give Insurance Cards and Photo ID to Receptionist to Copy)

Insured Name_____ Relationship to patient_____

Insured Birthdate_____ Insured SS #_____

Insured Employed By_____ Work Phone_____

Primary Insurance Name

Insurance Provider Billing Address_____

Policy #_____ Group #_____

Secondary Insurance Name

Insurance Provider Billing Address_____

Policy #_____ Group #_____

Referral Information, Patient Financial Policy and Signature On File

Other family members that are patients _____

Primary Care Physician _____Phone _____

In Case of Emergency (Contact Person) _____ Phone _____

How Did You Hear About Us? (Circle one)

Doctor / Family / Friend / Internet / Webpage / Facebook / Twitter / Magazine / Other _____

Do You Give Our Office Permission To Discuss Your Medical Information With Any One Else?

☐ YES ☐ NO If yes, please provide their names and phone numbers below.

#1 Name_____ Phone _____

#2 Name_____ Phone _____

#3 Name_____ Phone _____

#4 Name_____ Phone _____

May we leave personal medical information on your answering machine or cell phone? ☐ YES ☐ NO

May we e-mail personal medical information to you? ☐ YES ☐ NO

E-mail address (Please Print Legibly)

_____

Receipt Of Notice Of Privacy Practices

My signature below indicates that I have received and/or reviewed a copy of Lakeside Dermatology's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature _____ Date _____

Payment Policy

Self-Pay Patients- I understand that I am required to pay 100% of the total bill at the time of service.

Insured Patients- I understand that I will be responsible for paying my deductible, co-payment, co-insurance, and charges for any non-covered and/or cosmetic services.

Laboratory Services-I understand that if I have a skin biopsy and/or any other laboratory services performed, it will be sent to an outside laboratory to be tested and I may receive a bill from the laboratory. (For example: Ameripath, Quest, LabCorp, etc.)

Patient or Responsible Party Signature _____ Date _____

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Patient Name _____ Date_____

Past Medical History (Please circle all that apply)

Anxiety	Coronary Artery Disease	HIV/AIDS	Seizures
Arthritis	Depression	High Cholesterol	Stroke
Asthma	Diabetes Type _____	Thyroid Problems	**NONE**
Atrial Fibrillation	End Stage Renal Disease	Leukemia	Other_____
Bone Marrow Transplant	GERD	Lung Cancer	_____
Breast Cancer	Hearing Loss	Lymphoma	_____
Colon Cancer	Hepatitis A B or C	Prostate Cancer	_____
COPD	High Blood Pressure	Radiation Treatment	_____

Past Surgical History (Please circle all that apply)

Appendix	Joint Replacement, Hip (Rt, Lt, Both)	Ovaries Removed: Ovarian Cancer
Bladder Removed	Joint Replacement, Knee (Rt, Lt, Both)	Prostate Biopsy
Breast Biopsy (Right, Left, or Both)	Joint Replacement, Shoulder (Rt, Lt, Both)	Prostate Removed: Prostate Cancer
Breast Implants	Joint Replacement was within last 2 years	Prostate Removed: TURP
Breast Reduction	Kidney Biopsy (Nephrectomy)	Spleen Removed
Colectomy: Colon Cancer Resection	Kidney Removed (Right or Left)	Testicles Removed (Right, Left, or Both)
Colectomy: Diverticulitis	Kidney Stone Removal	Valve Replacement : Biological
Colectomy: IBD	Kidney Transplant	Valve Replacement: Mechanical
Coronary Artery Bypass	Lumpectomy (Right, Left, or Bilateral)	Transplant: Heart
Gallbladder Removed	Mastectomy (Right, Left, or Both)	**NONE**
Hysterectomy: Fibroids	Ovaries Removed: Cyst	Other_____
Hysterectomy: Uterine Cancer	Ovaries Removed: Endometriosis	_____

Skin Disease History (Please circle all that apply)

Acne	Dry Skin	Poison Ivy	Squamous Cell Skin Cancer (SCC)
Actinic Keratoses (AK)	Eczema	Precancerous Moles	**NONE**
Basal Cell Skin Cancer (BCC)	Flaking of Itchy Scalp	Psoriasis	Other_____
Blistering Sun Burns	Melanoma	Psoriasis	_____

Medications: (Please list all current prescription and/or OTC medications)

Name (Ex: Aspirin)	**Strength** (Ex: 81mg)	**Dose** (Ex: 1 tablet)	**Frequency** (Ex: at night)

Allergies (Please list all allergies)

Social History (Please circle all that apply)

Smoking Use	**Alcohol Use**	**Drugs Use**
Currently Smokes (How many packs per day? _____)	None	Currently Use _____
Former Smoker (How long ago did you stop? _____)	Less than 1 drink per day	Formerly Used _____
Total Years Smoked _____	1-2 drinks per day	Never Used Drugs
Never Smoked	3 or more drinks per day	IV Drug Use?

Family Medical History (Please only list first degree relatives and their history)

Assignment and Release

I hereby authorize payment directly to Michael J. Rogers, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in Lakeside Dermatology to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Responsible Party Signature _____ Date _____