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

Referral Information, Patient Financial Policy and Signature On File

Other family members that are patients _____

Primary Care Physician _____Phone _____

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 #_____

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_____Relationship_____ Phone _____

#2 Name_____Relationship_____ Phone _____

#3 Name_____Relationship_____ Phone _____

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

May we text reminders and personal medical information to you? ☐ 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, IRL, Quest, LabCorp, etc.) and *it is my responsibility* to inform Lakeside Dermatology, LLC staff if my insurance requires a particular laboratory.

Cancellation Policy-I understand that if I fail to give 48 business hours' notice to cancel or reschedule my appointment, that I will be required to pay a $150 Surgical Appointment or $50 Dermatologic Appointment fee.

Patient or Responsible Party Signature _____ Date _____

Assignment and Release

I hereby authorize payment directly to Michael J. Rogers, MD and Lakeside Dermatology, LLC 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 _____

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

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	_____

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

Pharmacy Name_____

Location_____Phone Number_____

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?

Do you have a living will? YES or NO

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

_____

_____

_____