



Associated Dermatologists

John C. Long Jr, MD
Phone (386) 672-3111
Fax (386) 672-6532
155 North Nova Road
Ormond Beach, FL 32174

Patient Information:

First, MI, Last Name: _____ S.S. # _____ Home Phone: _____
Address: _____ Apt: _____ Cell Phone: _____
City: _____ State: _____ Zip Code: _____ Country: _____
Date of Birth: _____ Age: _____ Birth Sex: _____ Email Address: _____
Employer: _____ Work Phone#: _____
Occupation: _____ How did you hear about our office? _____
Marital Status: _____ Spouse's Name: _____ Spouse Contact #: _____

Guarantor Information:

_____: Same as Patient First, MI, Last Name: _____ S.S. # _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____

Insurance Information:

Primary Insurance:
Ins Company Name: _____ ID#: _____ Group #: _____
Ins Contact # _____ Deductible/ Copay _____ Name of Subscriber _____
Patient Relation _____ Subscriber's SS# _____ Subscriber's D.O.B. _____
Subscriber's Birth Sex _____ Subscribers Tel # _____

Secondary Insurance:
Ins Company Name: _____ ID#: _____ Group #: _____
Ins Contact # _____ Deductible/ Copay _____ Name of Subscriber _____
Patient Relation _____ Subscriber's SS# _____ Subscriber's D.O.B. _____
Subscriber's Birth Sex _____ Subscribers Tel # _____

Medical History:

Current and Previous Medical Conditions: _____

Medications and Dosage: _____

Allergies to Medications and Reactions: _____

Please Read: Your signature below authorizes the doctor to release to your insurance company, or its representatives, such as medical information necessary to process your insurance claim(s), if any. **Your signature consents to the release of any information contained in the medical records which may include to infection with Human Immunodeficiency Virus (HIV), AIDS, or related condition, alcohol or drug dependence history or treatment, or any psychiatric or psychological records.** It also requests and authorizes your insurance company to make payments directly to the doctor for any and all services performed. **Payment for "your part" of the charges are expected at time of service.**

Signature of Patient

Signature of Responsible Party (if other than Patient)

Date _____

Confidential New Patient Questionnaire
Associated Dermatologists P.A.

*Please complete entire form and sign

Date: _____

What are you seeing the doctor for today? _____

How long has this been bothering you? _____

What have you tried for this problem(s)? _____

Did anything help? Yes No If yes, what? _____

Do you currently have, or have you recently had:

Fevers	<input type="checkbox"/> yes <input type="checkbox"/> no	Swallowing difficulty	<input type="checkbox"/> yes <input type="checkbox"/> no
Weight loss or gain	<input type="checkbox"/> yes <input type="checkbox"/> no	Vomiting/heartburn	<input type="checkbox"/> yes <input type="checkbox"/> no
Fatigue	<input type="checkbox"/> yes <input type="checkbox"/> no	Urinary frequency	<input type="checkbox"/> yes <input type="checkbox"/> no
Hair or nail changes	<input type="checkbox"/> yes <input type="checkbox"/> no	Urinary pain or blood	<input type="checkbox"/> yes <input type="checkbox"/> no
Loss of vision	<input type="checkbox"/> yes <input type="checkbox"/> no	Genital lesions	<input type="checkbox"/> yes <input type="checkbox"/> no
Distorted vision	<input type="checkbox"/> yes <input type="checkbox"/> no	Breast masses	<input type="checkbox"/> yes <input type="checkbox"/> no
Eye pain or soreness	<input type="checkbox"/> yes <input type="checkbox"/> no	Vaginal bleeding or discharge	<input type="checkbox"/> yes <input type="checkbox"/> no
Hearing difficulty	<input type="checkbox"/> yes <input type="checkbox"/> no	Joint pains or swelling	<input type="checkbox"/> yes <input type="checkbox"/> no
Dizziness	<input type="checkbox"/> yes <input type="checkbox"/> no	Muscle pain	<input type="checkbox"/> yes <input type="checkbox"/> no
Sinus congestion	<input type="checkbox"/> yes <input type="checkbox"/> no	Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no
Runny nose	<input type="checkbox"/> yes <input type="checkbox"/> no	Weakness or paralysis	<input type="checkbox"/> yes <input type="checkbox"/> no
Nosebleeds	<input type="checkbox"/> yes <input type="checkbox"/> no	Fainting or blackouts	<input type="checkbox"/> yes <input type="checkbox"/> no
Mouth dryness	<input type="checkbox"/> yes <input type="checkbox"/> no	Slurred speech	<input type="checkbox"/> yes <input type="checkbox"/> no
Chest pains	<input type="checkbox"/> yes <input type="checkbox"/> no	Anxiety	<input type="checkbox"/> yes <input type="checkbox"/> no
Palpitations	<input type="checkbox"/> yes <input type="checkbox"/> no	Depression	<input type="checkbox"/> yes <input type="checkbox"/> no
Cough	<input type="checkbox"/> yes <input type="checkbox"/> no	Easy bruising	<input type="checkbox"/> yes <input type="checkbox"/> no
Shortness of breath	<input type="checkbox"/> yes <input type="checkbox"/> no	Blood transfusions	<input type="checkbox"/> yes <input type="checkbox"/> no
Wheezing	<input type="checkbox"/> yes <input type="checkbox"/> no	Swollen lymph nodes	<input type="checkbox"/> yes <input type="checkbox"/> no
Excessive thirst	<input type="checkbox"/> yes <input type="checkbox"/> no	Temperature intolerance	<input type="checkbox"/> yes <input type="checkbox"/> no

Do you have or have you ever had any of the following conditions:

High blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no
Blood clots	<input type="checkbox"/> yes <input type="checkbox"/> no	Excess hair growth	<input type="checkbox"/> yes <input type="checkbox"/> no
Lung disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Keloids	<input type="checkbox"/> yes <input type="checkbox"/> no
Ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV	<input type="checkbox"/> yes <input type="checkbox"/> no
Hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Liver problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no

Cancer yes no **Type(s):** _____

Do you live alone? yes no

Do you smoke? yes no

Are you pregnant/planning? yes no

Do you drink alcohol? yes no

Personal or family history of melanoma? Yes No

Have you had 3 or more blistering sunburns before you were 20 years old? Yes No

Did you have 3 or more outdoor summer jobs as a teen? Yes No

Patient signature _____



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REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Date: _____
 Other family members that are patient's _____
 Referred by: _____ Primary Care Physician: _____
 PCP: Contact # _____ PCP Location _____
 Emergency Contact _____ Relation to Patient _____ Contact # _____

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date _____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/ supplemental carriers. However, in the event that the secondary does not pay within 30 days, patients will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 20% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____ Date _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself for the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card _____ Date _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MED/GAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MED/GAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as It appears on Medigap Card _____ Date _____

Due to new Governmental regulations, we are required to keep the following information in your medical records on each of your visits. All of the information and choices below are written exactly as mandated by the Government.

Do you have an Advance Care Plan or surrogate decision maker? Yes No (65 years and Older)

This is someone who you wish to make decisions for you if you were to become incapacitated.

Name of Surrogate/ Decision maker: _____

Relationship to Patient: _____

Tobacco Use: Screening and Cessation Intervention: (12 years and up)

Are you a Current Tobacco user? Yes No Former Tobacco user? Yes No

If YES do you have plans to quit? Yes No

Provided Patient with Verbal Counseling Tips to quit Smoking and printed Intervention

Document Yes Staff Initials _____

Screening for Future Fall Risk: (65 years and older)

Have you had 1 or more falls in the last year? Yes No

If yes. Did any result in injury? Yes No Is your PCP aware of the fall(s)? Yes No

Primary care provider _____

Have you ever been referred to Physical Therapy for Balance and Strength training? Yes No

Provided Patient with verbal and printed counseling, Tips to prevent Future falls Document

Yes Staff Initials _____

Patient Name: _____ Date: _____

Patient Signature: _____

(To be filled in by staff member) Patient MRN #: _____

IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Dr. Long is here to provide you with the best medical care. His primary concern is your health and well-being, not your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

It is very important for you to read your insurance policy very carefully. As we participate with numerous insurance companies, and each company has many different plans, we cannot possibly be aware of each patient's particular coverage. You will receive a bill if the service is one that is not covered under your policy. It is very important that you are familiar with the benefits and policies of your insurance plan including medications that are covered.

I have read the above and understand that I am responsible for knowing the coverage and benefits of my insurance policy.

Patient's Signature

Date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

USE OF PROTECTED HEALTH INFORMATION FOR APPOINTMENT REMINDERS

- I authorize Associated Dermatologists to remind me of upcoming appointments by calling my home phone number. This consent includes leaving a message if necessary.
(Initial here) _____
- I **do not** wish to be reminded of my upcoming appointments. I understand that if I fail to give 2 days' notice of a cancellation I will be charged a \$25 fee for a missed appointment.
(Initial here) _____

No medical information will be released. These calls are just to verify appointment day and time

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Associated Dermatologists
John C. Long, Jr. MD
155 N. Nova Road
Ormond Beach, FL 32174
ATTN: Privacy Officer



**AUTHORIZATION TO DISCUSS
HEALTHCARE INFORMATION**

I, _____ Date of Birth: _____, give permission to Associated Dermatologists to disclose and discuss my protected health information described below to:

Name(s):

Relationship:

HEALTH INFORMATION TO BE DISCLOSED (Check all that apply):

- My complete health record (including but not limited to both medical and cosmetic: diagnoses, lab tests, prognosis, treatment, scheduling and billing, for all conditions)

OR

- My complete health records, as above, with the exception of the following information: (please specify):

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Associated Dermatologists, preferably in writing.)

Name of the Individual Giving this Authorization

Signature of the Individual Giving this Authorization

Date



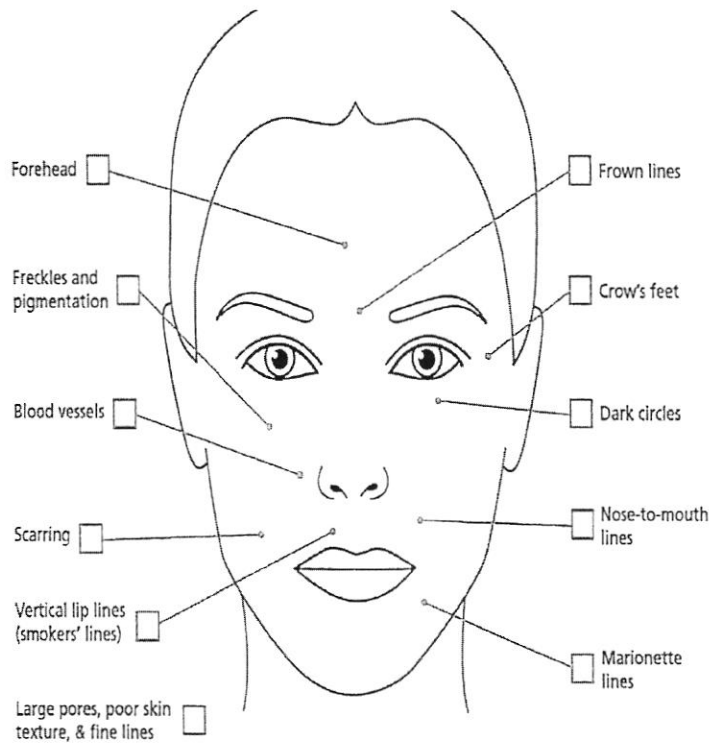
Associated Dermatologists

Cosmetic Questionnaire

I would like Dr. Long to make Cosmetic treatment recommendation to address my areas concern.

YES OR NO

Please identify all areas of personal concern:



What are your cosmetic concerns? (Please Circle all that apply)

Sun Spots/Age Spots Fine Lines/Wrinkles Breakouts Skin Care

Skin Texture Discoloration Spider Veins Scarring Redness/Blotchy

Eyelash Length/Fullness Facial Sagging Double Chin/Jowls Thin Lips

I am interested in a skincare routine and products appropriate for my age. YES NO

I would like to be contacted by the esthetician to schedule a complimentary skin care consultation? YES NO

Name _____

Phone Number: _____

Email _____