Dermatology Solutions

Debra Fett Desmond M.D. - Mary Frances Pilcher M.D. - Tiffany Jordan PA-C - Cynthia Feagan, ARNP

Last Name: _____ First Name: _____ MI:_____

DOB:_____Marital Status: _____ Spouse's Name:_____

Home Phone: _____ Cell: _____Other:_____

Email : _____

Street Address: _____City: _____State: _____Zip:_____

Secondary Address: _____City: _____State: _____Zip:_____

Preferred Pharmacy : _____ Location:_____ Pharmacy Phone:_____

Emergency Contact: _____ Contact Phone:_____

My Medical Information May Be Disclosed To: _____

Detailed test results may be left on answering machine (circle one): YES NO

If yes, what number(s) may we leave detailed results on? _____

Insurance Information:

Primary Insurance:_____

Secondary Insurance:_____

Primary Subscriber: _____ Date of Birth: _____

I understand that I am fully and legally responsible for all charges for services rendered, which include all outstanding balances not covered by Medicare and/or insurance companies. I understand there may be certain procedures which my insurance will not cover. These procedures will be discussed with me prior to the procedure and I understand that I will be fully responsible for those amounts. I understand that I am responsible for all co-payments, deductibles, co-insurance, and non-covered services. I understand that all payments are due at time of service. I authorize payment directly to Dermatology Solutions (Dr. Debra Fett Desmond) of my insurance benefits, otherwise payable to me, but not to exceed the balance due of the centers regular charges. I understand that failure to pay my account or to make suitable financial arrangements to pay my account may result in my account being turned over to a collection agency, in which I will be responsible for charged interest, collection fees, and/or attorney fees. **For all non-payments going to collections, a thirty percent collection fee will be added.** I understand my signature authorizes payments to be made, and authorizes release of medical information necessary to pay a claim. My signature below authorizes release of my medical information to the insurer of agency shown above. I understand that I may receive a copy of this Insurance Policy for Dermatology Solutions upon request. I hereby consent to the examination, treatment, payment, and procedures which may be performed during this and subsequent visits, including emergency treatment deemed necessary by Dermatology Solutions staff.

Patient/Guardian Signature: _____ Date: _____

History and Intake Form

Referring Physician:_____ Family Doctor: _____

Chief Complaint:_____

Treatments/Medications tried/outcome: _____

Past Medical History: _____
_____
_____

Past Surgical History: _____
_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Other _____
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles (Dysplastic Nevus)
Psoriasis
Squamous Cell Skin Cancer

14071 Metropolis Ave., Fort Myers, Fl. 33912
Phone: 239-694-7546 Fax: 239-694-1571

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Do you wear Sunscreen? Yes / No If yes, what SPF? _____
Do you tan in a tanning salon? Yes / No
Family history of Melanoma? Yes / No If yes, which relative(s)? _____

Any other family history? >_____

Medications: (Please enter all current medications or provide list to copy)_____
_____
_____

Allergies: (Please enter all allergies)
_____

Social History: (Please circle one)

Cigarette Smoking:	Alcohol Use:	Language:	
Never smoked	YES	English	French/Creole
Quit: former smoker	NO	Spanish	German
Smokes less than daily		Other:_____	
Smokes daily			

What is your occupation?:_____

Review of Systems (Please elaborate on any problems you might have):

Problems with fever, weight loss, weakness? >_____
Problems with Eyes, Ears, Nose, Throat? >_____
Problems with Lungs, Chest, Heart? >_____
Problems with Abdomen, Digestion? >_____
Problems with Bones, Muscles, Tendons, Joints? > _____
Problems related to the Brain, Mood? > _____

HIPAA: (Health Insurance Portability and Accountability Act)

I hereby consent to the examination, treatment, payment, and procedures which may be performed during this and subsequent visits, including emergency treatment deemed necessary by the Dermatology Solutions staff. We might share your healthcare information with your physician for payment activities related to the care you received. Your PHI (Protected Health Information) may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence. Your PHI may be released to other healthcare providers in the event you need emergency care. Your PHI may be released to a public health or organization or federal organization in the event of a communicable disease or to report a defective device. Your PHI may be released after receiving written authorization from you, other than those listed above or for treatment, payment, or healthcare operations. You may revoke your permission to release PHI at any time. It must be in writing with effective date and be specific to the health information being protected. You may be contacted by us via phone or mail (or leave a message on an automated answering device) to remind you of appointments, pre-scheduled procedures, verify insurance/demographic information, or inform you of test results. You have the right to request a more confidential way of providing your PHI or alternative communication method at the time you are seen. We will honor all reasonable requests. You have the right to receive confidential communication about your health information to notify or assist in the notification of a family member, your personal representative, or another person responsible for your care. You have the right to review and photocopy any/all portions of your health information. We have the right to assess a fee for photocopying of health information. You have the right to know who has accessed you PHI and for what purpose other than treatment, payment, healthcare operations, and other activities.

Patient/Guardian Signature:_____Date:_____

Print Patient Name:_____

Office use only:
Confirmation Sign:
Notes:_____
_____

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