Associated
Dermatologists
www.AssociatedDerm.com

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

Patient Information:

Patient's Name: _____ S.S.# _____
Address: _____ Apt: _____ Home Tel. # _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Male: _____ Female: _____
Employer: _____ Work Tel. # _____
Occupation: _____ How did you hear of our office? _____
Marital Status: _____ Spouse's Name: _____
Spouse's Employer: _____ Spouse's Work Tel. # _____
Email Address: _____
If patient is a minor or student, name of responsible party: _____ Relationship: _____
Address: _____ Home Tel. # _____
City: _____ State: _____ Zip Code: _____

Insurance Information:

Medicare:
_____ Deductible: _____ Have you met your deductible? _____

Other Insurance: (Name) _____
I.D.# _____ Group# _____
Deductible/Co-Pay: _____ Have you met your deductible? _____
Subscriber Name: _____ S.S.# _____ DOB: _____
Relationship of Subscriber to Patient: _____

Medical History:

Current and Previous Medical Problems: _____

_____

Current Medications: _____

_____

Allergies: _____

PLEASE READ: ***Your signature below authorizes the doctor to release to your insurance company, or its representatives, such 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 infection with Human Immunodeficiency Virus (HIV), AIDS, or related conditions, alcohol or drug dependence history or treatment, or any psychiatric or psychological records. It also requests and authorizes your insurance company to make payment directly to the doctor for any and all services performed. Payment for "your part" of the charges are expected at the time of service.***

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

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

High blood pressure	☐ yes ☐ no	Diabetes	☐ yes ☐ no
Heart disease	☐ yes ☐ no	Thyroid problems	☐ yes ☐ no
Anemia	☐ yes ☐ no	Glaucoma	☐ yes ☐ no
Blood clots	☐ yes ☐ no	Excess hair growth	☐ yes ☐ no
Lung disease	☐ yes ☐ no	Keloids	☐ yes ☐ no
Ulcers	☐ yes ☐ no	HIV	☐ yes ☐ no
Hepatitis	☐ yes ☐ no	Kidney disease	☐ yes ☐ no
Liver problems	☐ yes ☐ no	Stroke	☐ yes ☐ no
Cancer	☐ yes ☐ no	type: _____	

Do you live alone?	☐ yes ☐ no	Are you pregnant/planning?	☐ yes ☐ no
Do you smoke?	☐ 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

Did a doctor refer you to our office? ☐ yes ☐ no If yes, who? _____

Patient Signature _____ **Doctor Signature** _____

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REFERRAL INFORMATION, PATIENT FINANCIAL POLICY, AND SIGNATURE ON FILE

Patient Name: _____ Today's Date ____/____/_____
Other family members that are patients: _____
Referred by: _____ Primary Care Physician: _____
In case of Emergency, who should be notified? _____ Phone: _____

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

Signature as it appears on Medigap Card _____ **Date ____/____/_____**