2804 St. Johns Bluff Rd. S, #109
Jacksonville, FL 32246
(904) 727-9123
Fax (904) 855-4255

183 Landrum Lane, #201
Ponte Vedra Beach, FL 32082
(904) 567-1050
Fax (904) 567-1051

Welcome to our practice. Please complete the following forms. Please PRINT all information. Thank you.

PRIMARY LANGUAGE:_____ RACE:_____ETHNICITY:_____

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE INITIAL)

CHECK ONE: SEX M ___F ___ MARRIED:___SINGLE:___WIDOWED:___DIVORCED:____

DATE OF BIRTH:_____ SOCIAL SECURITY NO._____

PATIENT'S ADDRESS: _____
STREET ADDRESS / APARTMENT NUMBER

_____
(CITY) (STATE) (ZIP)

HOME TELEPHONE NO.: _____MOBILE PHONE NO.: _____

EMPLOYED BY:_____OCCUPATION_____

BUSINESS ADDRESS:_____BUSINESS PHONE :_____

NAME & PHONE NUMBER OF EMGERGENCY CONTACT:_____

IF UNDER 18, PARENT/GUARDIAN NAME AND PHONE NO. _____

EMAIL ADDRESS (FOR PATIENT PORTAL):_____

PRIMARY CARE PHYSICIAN:_____
NAME AND PHONE NUMBER

REFFERRED BY:_____ PHARMACY NAME & NO._____

INSURANCE INFORMATION

For your protection, patients(s) and/or legal guardian must provide a valid photo identification card along with appropriate insurance cards. We hope you understand we cannot make exceptions.

_____ ***CHECK HERE IF YOU DO NOT HAVE INSURANCE OR DO NOT PLAN TO USE YOUR INSURANCE BENEFITS.***

PRIMARY INSURANCE_____ POLICY ID:_____

GROUP#_____

ADDRESS:_____

POLICY HOLDER:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____ SOC. SEC #:_____

SECONDARY INSURANCE:_____ POLICY ID:_____

ADDRESS:_____

POLICY HOLDER:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____ SOC. SEC #:_____

COASTAL DERMATOLOGY, PA

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MEDICAL HISTORY

1. Reason for today's visit: _____

_____

2. Medical History (Include any prior or current medical problems, serious illnesses or injuries, operations, skin problems or skin cancers.

_____

_____

3. Family History (Include any illnesses or diseases including skin problems or skin cancers.

_____

_____

4. Please list all medications including non-prescription drugs that you take regularly:

_____

_____

5. Please list known drug allergies or reactions you may have had to any medications:

_____

6. Please provide any additional information you feel may be helpful to us:

_____

7. Would you like information on any of the following?

_____Treatment of sun damaged skin
_____Improving skin texture and tone or removal of unwanted hair
_____Personalized skin care regiment/Physician Grade Products
_____Reduction of fine/deep lines & wrinkles
_____Botox
_____Fillers (Juvederm, Sculptra, Radiesse)
_____Physician grade facials or chemical peel
_____Vaser Liposelection (body contouring)
_____Acne Scarring
_____Lasers

_____ _____

Printed Name Date

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Acknowledgements/Authorizations:

- In the event that it is necessary to cancel or reschedule your appointment, we ask that you notify us at least 24 hours before your scheduled appointment. This allows us to make that time available for another patient. If we receive inadequate notice or you miss the appointment, you may be charged a missed exam/surgery fee.

- If a personal or business check is issued by you or on your behalf is returned unpaid for any reason by the financial institution, an additional fee as determined by vendor policy or Florida Statute will be added to the amount owed. **STATEMENT OF FINANCIAL RESPONSIBILITY**

- I acknowledge I am financially responsible for all charges for services provided to me, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, an HMO or any other payer. I also acknowledge that if I fail to pay for services provided and not paid by any health care plan(s), my account may be forwarded for collection and I will also be responsible for any collection-related charges and that information will be reported to credit reporting agencies. Additionally, I acknowledge Coastal Dermatology will not submit claims to my health insurance carrier for services deemed cosmetic.

- I authorize Coastal Dermatology, PA to release all medical information necessary to all insurance carriers or any other payers; person(s) I have designated as guarantor for the billing, payment and coverage for my account; any other health care providers for treatment purposes.

- I authorize my insurance carrier, health plan administrator or any other payer to pay directly to Coastal Dermatology any benefits due under the terms of my health care plan(s) for services provided by same. I understand Coastal Dermatology reserves the right to refuse or accept assignment of medical benefits. If my plan will not allow direct payment to Coastal Dermatology or if the provider chooses not to accept assignment, I agree to immediately forward all health care payments I receive for those services provided by Coastal Dermatology. I authorize Coastal Dermatology to contact my insurance carrier, health plan administrator, other payer or review agencies to obtain all pertinent benefit and financial information concerning coverage and payments made under my health plan. I further authorize my insurance carrier, health plan administrator, and any other payer, agents or review agencies to release such information to Coastal Dermatology.

_____ _____

Patient/Guarantor Signature Date

_____

Printed Name

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PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

___ HOME PH: _____

___ O.K. to leave message with detailed information

____Leave Message with call back number only.

___ Work Ph:_____

___ O.K. to leave message with detailed information

____ Leave Message with call back number only

___ Written Communication

___ O.K. to mail to home address

___O.K. to mail to work address

____Ok to fax to this number:_____

I authorize Coastal Dermatology PA to discuss my PHI with the following individual(s):

_____
Name of Authorized Individual

_____ _____
Patient Signature Date

_____
Printed Name

COASTAL DERMATOLOGY & MEDSPA

2804 St. Johns Bluff Rd. S, #109
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(904) 727-9123
(904) 855-4255 Fax

183 Landrum Lane #201
Ponte Vedra Beach, Fl 32082
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(904) 567-1051 Fax

Attention Patients!!! We are updating our method of contact for your appointment reminders, we are now sending text message and email reminders for up-coming appointments!! Please provide your most current cell phone number and e-mail address.

Thank you,

Coastal Dermatology

PATIENT NAME AND DOB:_____

PLEASE CHECK ONE:

☐ **I WOULD LIKE TEXT MESSAGE REMINDERS.**

CELL PHONE #_____

☐ **I WOULD LIKE EMAIL REMINDERS.**

EMAIL ADDRESS:_____

☐ **I DO NOT WISH TO HAVE EITHER. PLEASE JUST CALL.**

Coastal Dermatology & Medspa

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Coastal Dermatology & Medspa. I hereby acknowledge receipt of Coastal Dermatology & Medspa's Notice of Privacy Practices.

Name and Date of Birth [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Coastal Dermatology & Medspa's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

COASTAL DERMATOLOGY, PA

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JACKSONVILLE, FLORIDA 32246

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FAX NO: (904) 855-4255

183 LANDRUM LANE, STE 201

PONTE VEDRA BE ACH, FL 32082

PHONE: (904) 567-1050

FAX NO: (904) 567-1051

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

PHARMACY:_____

APPROXIMATE HEIGHT_____WEIGHT_____

HAVE YOU HAD THE FLU VACCINE_____

HAVE YOU HAD THE PNEUMOCCAL VACCINE_____

ARE YOU A SMOKER_____

DO YOU DRINK ALCOHOL_____

IF YES, HOW MANY DRINKS DAILY_____WEEKLY_____

HAVE YOU CONSUMED 5+ DRINKS IN ONE DAY IN THE PAST YEAR_____

EMAIL ADDRESS:_____

PRIMARY CARE PHYSICIAN:_____

REFERRED BY:_____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the pro... copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name. Address. Phone of Recipient of Records)						
Name					Phone	
Address						
City/State Zip	City		State		Zip	

RECORDS FROM: (Who is Releasing the Records)						
Name					Phone	
Address						
City/State Zip	City		State		Zip	

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-up
☐	Disability Insurance	☐	Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

☐	Please send the entire Medical Record (all information) to the above named recipient.				
☐	Office Notes and Reports	☐	Diagnostic Reports	☐	Billing Statements
☐	Rx History	☐	Transcribed Hospital Reports	☐	Laboratory Reports
☐	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____