NEW PATIENT INTAKE SHEET

Thomas S. Breza MD
Thomas S. Breza JR., MD
Stacey McFadden PA-C

Patient Name
Circle Which Applies
MR. MRS. MS. Dr. (First, MI, Last) _____

Date of Birth: _____/_____/_____

Primary Address

Street _____

City _____ State _____ Zip Code _____

Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact

Name: _____ Relationship to patient: _____

Cell Phone: _____ Work Phone: _____

Pharmacy

Name: _____ Phone Number: _____

Address _____

To whom should the account be addressed if the patient is a child:

Name: _____ Date of Birth: _____/_____/_____

Signature of Patient: _____ Date: _____

Dermatology by the Sea
4341 Bougainvilla Drive
Lauderdale by the Sea, Fl 33308
P:954-492-8866 F:954-492-8865
dermatologybythesea.com

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MEDICAL INFORMATION

Please list any allergies to medications: ☐ No known allergies

_____

_____

_____

Immunizations: ☐ Pneumococcal (pneumonia) ☐ Influenza ☐ Covid

Please check any relevant past medical/surgical history:

☐ Mohs Procedure
☐ High Blood Pressure
☐ Diabetes
☐ High Cholesterol
☐ Cancer
☐ Heart Disease
☐ Stroke
☐ Blood clots
☐ Asthma
☐ Pacemaker
☐ Epilepsy
☐ Depression / Anxiety

Other illness/surgery _____

Please list current medications:

_____

_____

_____

_____

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Disclosure of Medical Records

Patient Name: _____ Date of Birth: _____/_____/_____

In addition to the patient AND treating doctors, such as family members and/or friends, please indicate whom we may give test results and/or medical record information to:

Name(s) of whom we may give results to:

_____

_____

☐ Please **DO NOT** discuss my healthcare with anyone but myself.

Signature of Patient _____ Date _____

Acknowledgement of Patient Responsibility

Please be aware that we do our best to verify your eligibility and benefits prior to your appointment time, but it is ultimately the patient's responsibility to know what your benefits are and whether we are in or out of network with your insurance policy. If there is any remaining balance after your insurance company processes your claim, it is patient responsibility. It is also the patient's responsibility to inform us of any demographic changes as well as insurance changes (including Obamacare) since your last appointment. Thank you for your cooperation.

Please be aware that you are responsible for the cost of the appointment on the day of your appointment, including but not limited to your deductible, out of pocket, co insurance, and copay.

I acknowledge my responsibilities as a patient in the practice.

Signature of Patient _____ Date _____

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Notice of Privacy Practices Acknowledgements

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: • Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____

Relationship to patient (Circle one) SELF PARENT OTHER

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: Initials: Reason:

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