ALTAMONTE DERMATOLOGY

Patient Registration

Last Name: _____ First Name: _____ Middle:_____
Date of Birth: _____ Birth Sex: ▢ Female ▢ Male ▢ Other
Language: ▢ English ▢ Spanish ▢ Other: _____

Contact Information

The following information will assist us in communicating with you about your care while protecting your confidentiality. When we return calls and reach your voicemail, we do not leave a message if the voicemail recording does not state the patient name. Information will also not be left with an unauthorized person who may answer the phone.

Preferred Method(s) of Contact: ▢ Phone ▢ Email
Phone Numbers: Home: _____ Work: _____ Mobile: _____
Preferred Phone: ▢ Home ▢ Work ▢ Mobile Is it OK to leave a detailed message? ▢ Yes ▢ No
Email: _____
Emergency Contact: _____ Emergency Contact Phone Number: _____
Spouse/Partner: _____ Spouse/Partner Phone Number: _____

Advance Care (for Patients 65 years of age and older)
Do you have a health care proxy in the event you are unable to make your own medical decisions? ▢ Yes ▢ No
If Yes: Designee's full name: _____ Designee's Phone Number: _____

Address

Street Address: _____
City: _____ State: _____ ZIP code: _____
Marital Status: ▢ Married ▢ Single ▢ Divorced ▢ Widowed ▢ Partner

Release of Protected Health Information (PHI)

We cannot discuss patient health information with anyone other than the patient and/or their guardian unless we authorize us to do so. Please list below names of the individuals including **guardians** that you authorize our office to discuss care and **share health information with:**

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

ALTAMONTE DERMATOLOGY

Health History

Patient Name: _____
Date of Birth: _____

Primary Care Provider (First & Last Name): _____ Phone Number: _____
Preferred Pharmacy: _____ Phone Number: _____
Pharmacy Address: _____ Zip Code: _____

Past Medical Conditions / Chronic Medical Problems	Date Diagnosed

Past Surgeries	Date Performed

Skin Conditions

- ☐ Acne
- ☐ Atopic dermatitis (eczema)
- ☐ Basal cell carcinoma
- ☐ Dysplastic nevus
- ☐ Malignant melanoma
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seborrheic dermatitis
- ☐ Squamous cell carcinoma
- ☐ Urticaria (hives)
- ☐ Vitiligo
- ☐ Other: _____

Has someone in your family had melanoma?

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other: _____

Patient Name: _____
Date of Birth: _____

Medication	Dose (mg or units)	Frequency

Allergies	
Medication or Substance	**Reaction**

Smoking Habits

▢ Never smoker ▢ Former smoker
▢ Current everyday smoker ▢ Current some day smoker (tobacco) ▢ Current some day smoker (cigarette)
▢ Cigar smoker ▢ Heavy tobacco smoker ▢ Light tobacco smoker

Alcohol Use

▢ None ▢ Less than 1 drink per day ▢ 1-2 drinks per day ▢ 3 or more drinks per day

Occupation

Occupation and workplace: _____

Patient Attestation

By signing below:

- I certify that the **Patient Registration** and **Health History** information entered is my personal information, has not been fraudulently derived, and is or remains accurate and complete to the best of my knowledge. I understand that it is my responsibility to notify Altamonte Dermatology of any changes to this information.
- I acknowledge that I have read, understood, and agreed to the **Consent to Treatment and Financial Agreement** (https://www.altamontedermatology.com/consent-to-treatment), and that I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction, that this form has been fully explained to me and that I understand all of the information in this Consent to Treatment and Financial Agreement.
- I have received a copy of Altamonte Dermatology's **Notice of Privacy Practices** (https://www.altamontedermatology.com/privacy-policy). I understand that Altamonte Dermatology has the right to change its Notice of Privacy Practices from time to time and that I may contact Altamonte Dermatology at any time to obtain a current copy of the Notice of Privacy Practices.
- I acknowledge that I have read, understood, and agreed to the **Release for Provider Interaction Content** (https://www.altamontedermatology.com/modmed-release-for-provider-interaction), and that I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.
- I acknowledge that I have read, understood, and agreed to the **Authorization for Use and Disclosure of Protected Health Information for Recording** (https://www.altamontedermatology.com/modmed-hipaa-auth), and that I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient or Legal Representative | Legal Relationship to Patient

For Office Use Only - To be completed only if no signature is obtained.

I have made a good faith effort to obtain the patient's signature on this form, but was not able to do so for the following reason:

- ☐ Patient (or Patient's Representative) refused to sign
- ☐ Other: _____

Signature of representative: _____ Date: _____