Jerri L. Johnson, M.D.
Dermatology and Dermatologic Surgery
411 Maitland Avenue, Ste. 1001
Altamonte Springs, FL 32701

Patient Information

MRN: _____ *(Office Use Only)*

Date: _____

Patient Information

Legal Name: _____
(Last) Mr. Mrs. Ms. (First) (Middle)

Mailing Address: _____
(Street) (City) (State) (ZIP)

Phone: ( ) _____ ( ) _____ _____ ( ) _____
(Home) ☐ Best Number **(Work)** ☐ Best Number (Ext) **(Cell)** ☐ Best Number

Date of Birth: _____ **Age:** _____ ☐ Male ☐ Female **Social Security Number**: _____

Marital Status: ☐ Single ☐ Divorced ☐ Married _____ ☐ Widowed ☐ Child
(Name of Spouse)

Referred By: _____ **Email Address:** _____

Family Physician: _____ **Patient's Occupation:** _____

Address: _____ **Patient's Employer or School:** _____

Phone: ( ) _____ **Student Status:** ☐ Full Time ☐ Part Time

Emergency Contact (other than spouse) _____ _____
(Name) (Relationship)

_____ ( ) _____
(Address) (Phone Number)

Have you or anyone in your immediate family been a patient in our office before? ☐ Yes ☐ No If yes, list below:

Name: _____ Relationship: _____ When: _____

Person Responsible for Bill

Legal Name: _____
(Last) Mr. Mrs. Ms. (First) (Middle)

Mailing Address: _____
(Street) (City) (State) (ZIP)

Phone: ( ) _____ ( ) _____ _____ ( ) _____
(Home) ☐ Best Number **(Work)** ☐ Best Number (Ext) **(Cell)** ☐ Best Number

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other (Specify) _____

☐ Male ☐ Female Social Security Number: _____

Insurance Information

Primary Insurance

Company: _____
Address: _____
ID # _____
Group # _____
Employer: _____
Who is the Insured? ☐ Self ☐ Spouse ☐ Other

Insured Information if other than patient:

_____ _____
(Name) **(Date of Birth)**

_____ _____
(Relationship to Patient) **(Social Security #)**

Secondary Insurance

Company: _____
Address: _____
ID # _____
Group # _____
Employer: _____
Who is the Insured? ☐ Self ☐ Spouse ☐ Other

Insured Information if other than patient:

_____ _____
(Name) **(Date of Birth)**

_____ _____
(Relationship to Patient) **(Social Security #)**

I hereby give consent to Jerri L. Johnson, M.D., P.A. to provide the necessary treatment. I am aware that the pathology service for evaluation and diagnosis of tissue specimen(s) will be sent to an outside laboratory. This service may result in a separate co-pay/bill as determined by your insurance company. I am aware that payment is expected at the time service is rendered.

Signature: _____ **Date:** _____ / _____ / _____

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History and Intake Form

Patient Name: _____ MRN: _____ Date:_____

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Patient Demographics

Date of Birth: ____ / ____ / _____

Gender: ___ Male ___ Female

Preferred Language: _____

Email Address: _____

Race (Please check one):

___ White
___ American Indian or Native Alaskan
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ Other Race

Ethnic Group (Please check one):

___ Hispanic or Latino
___ Not Hispanic or Latino

Past Medical History / Problem List (Please check all that apply)

____ Anxiety
____ Arthritis
____ Asthma
____ Atrial fibrillation
____ BPH (Enlarged Prostate)
____ Bone Marrow Transplantation
____ Breast Cancer
____ Colon Cancer
____ COPD (Chronic Lung Disease) / Emphysema
____ Coronary Artery Disease
____ Depression
____ Diabetes (___ Insulin ___ Non-Insulin)
____ End Stage Renal Disease
____ GERD (Acid Reflux)
____ Hearing Loss
____ Hepatitis
____ HIV / AIDS
____ Hypercholesterolemia
____ Hypertension (High Blood Pressure)
____ Hyperthyroidism
____ Hypothyroidism
____ Leukemia
____ Lung Cancer
____ Lymphoma
____ Prostate Cancer
____ Radiation Treatment
____ Seizures
____ Stroke
____ Other_____

Medications

Medication	**Dosage**	**Frequency**

Social History (Please check all that apply)

Alcohol Use:

___ None
___ Less than 1 drink a day
___ 1-2 drinks a day
___ 3 or more drinks a day

Cigarette Smoking:

___ Never smoked
___ Quit: Former smoker
___ Few (1-3)cigarettes per day
___ Up to 1 pack per day
___ 1-2 packs per day
___ 2 or more packs per day

How long have (did) you smoked? _____

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Family History (Please list any major illness)

Father: _____ Brother(s): _____

Mother: _____ Sister(s): _____

Allergies to Medications ____ Yes ____ No

Name of Medication: _____

Reaction Location

____ Skin
- ____ Rash - localized
- ____ Rash - generalized
- ____ Itchiness
- ____ Patch swelling - skin
- ____ Facial swelling
- ____ Hives

Severity of Reaction:
- ____ Very Mild
- ____ Mild
- ____ Moderate
- ____ Severe

____ Abdominal
- ____ Rash - localized
- ____ Bloating / Gas
- ____ Vomiting
- ____ Diarrhea
- ____ Nausea

Onset:
- ____ Childhood
- ____ Adulthood
- ____ Unknown

____ Systemic / Anaphylactic
- ____ Shortness of breath
- ____ Wheezing
- ____ Tongue swelling
- ____ Dizziness / lightheadedness
- ____ Loss of consciousness
- ____ Difficulty speaking or swallowing
- ____ Chest pain
- ____ Irregular heartbeat
- ____ Tachycardia
- ____ Bradycardia
- ____ Respiratory distress

Name of Medication: _____

Reaction Location

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Patient Name: _____ MRN: _____ Date:_____
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Past Surgical History (Please check all that apply)

____ Appendix Removed
____ Bladder Removed
____ Breast Implants
____ Breast Reduction
____ Colectomy: Colon Cancer Resection
____ Colectomy: Diverticulitis
____ Colectomy: IBD
____ Gallbladder Removed
____ Hip Replacement (___ Right ___ Left)
____ Hysterectomy: Fibroids
____ Hysterectomy: Ovarian Cancer
____ Knee Replacement (___ Right ___ Left)
____ Kidney Removed (___ Right ___ Left)
____ Kidney Stone Removal
____ Kidney Transplant
____ Lung Transplant
____ Mastectomy (___ Right ___ Left)
____ Ovaries Removed: Cyst
____ Ovaries Removed: Endometriosis
____ Ovaries Removed: Ovarian Cancer
____ Prostate Removed
____ Spleen Removed
____ Testicle(s) Removed
____ TURP (Prostate Surgery)
____ Other _____
_____
_____
_____
_____

- - - Heart Disease - - -
____ Coronary Artery Bypass
____ Defibrillator
____ Heart Attack (MI)
____ Heart Transplant
____ Heart Valve Replacement – Biological
____ Heart Valve Replacement – Mechanical
____ Pacemaker
____ PTCA (Angioplasty)

- - - Skin Cancer - - -
____ Melanoma Surgery
____ Non-Melanoma Skin Cancer Surgery

Skin Cancer / Disease History:
(Please check all that apply)

____ Acne
____ Actinic Keratoses (pre-cancers)
____ Blistering Sunburns
____ Dry Skin
____ Eczema
____ Flaking or Itchy Scalp
____ Hay Fever / Allergies
____ Poison Ivy
____ Precancerous Moles
____ Psoriasis
____ None
____ Basal Cell Carcinoma
____ Squamous Cell Carcinoma
____ Melanoma
____ Other _____

Do you wear sunscreen? ___ Yes ___ No
If yes, what SPF? _____

Do you have a family history of melanoma? ___ Yes ___ No
If yes, which relative(s)? _____

Do you have a history of tanning bed use? ___ Yes ___ No

Review of Systems
Are you currently experiencing any of the following?
(Please check all that apply)

____ Pregnant or planning a pregnancy
____ Swollen lymph nodes
____ Problems with bleeding
____ Immunosuppression
____ Sore throat
____ Cough
____ Shortness of breath
____ Asthma
____ Rash with sun exposure
____ Hay Fever
____ Chest pain
____ Fever or chills
____ Night sweats
____ Unintentional weight loss
____ Thyroid problems
____ Abdominal pain
____ Bloody stool
____ Bloody urine
____ Arthritis
____ Muscle weakness
____ Muscle pain(s)
____ Headaches
____ Seizures
____ Anxiety
____ Blurry Vision
____ Depression
____ Other Symptoms: _____
_____

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Alerts

Are you currently experiencing any of the following?
(Please check all that apply)

____ Allergy to lidocaine
____ Allergy to topical antibiotic ointment
____ Artificial heart valve
____ Defibrillator
____ Pacemaker
____ Premedication prior to procedure
____ Joint replacement
____ Bleeding disorder
____ Other_____

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Phone Number: ( ) _____

(Please allow 8 hours for prescriptions to be filled. Thank you.)

Signature: _____ **Date:** ___ / ___ / _____

(Parent or Guardian Signature if child is a minor)

Jerri L. Johnson, M.D.
Dermatology and Dermatologic Surgery

Patient Authorization to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

Patient Name: _____ Date of Birth: _____

I have been provided with a *"Notice of Privacy Practices"* that provides a more complete description of information uses and disclosures. I understood that I have the following rights and privileges:

- The right to review the *"Notice"* prior to acknowledging this authorization
- The right to restrict or revoke the use or disclosure of my health information
- The right to request restrictions as to how my health information may be used or disclosed

Please tell us with whom we may discuss the patient's treatment, payments or health care operation. **Examples:** Spouse (name), children (names), other relative(s) (names), friends or caregivers (names). *PLEASE PRINT INFORMATION BELOW*

_____	_____	(____)_____
Name	*Relationship*	*Phone*
_____	_____	(____)_____
Name	*Relationship*	*Phone*
_____	_____	(____)_____
Name	*Relationship*	*Phone*
_____	_____	(____)_____
Name	*Relationship*	*Phone*

I acknowledge that I have been given on opportunity to read and review the *Notice of Privacy Practices* for the office of JERRI L. JOHNSON, M.D., P.A ..

I fully understand and **accept _____ decline_____** the information of this authorization

_____ _____

Patient/Guardian Signature Print name of person signing

If other than patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare options? Yes _____ No _____

Notice of Privacy Practices

Jerri L. Johnson, M.D., P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and im proving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPPA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by **it** unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer at 407-260-2606 for more information, in person or in writing.