Goodless Dermatology
Quality skincare for your entire family

Please verify that the following information is current, correct and fill in anything that is left blank. Thank you.

Today's Date: ______________________________

Patient Information:

Name	Date of Birth	Circle One: Male/Female

Address

Email

Contact Information:

MAY WE LEAVE DETAILED MESSAGES (i.e. Appointments, billing, results, etc.)?

Home #: (____) ____________________	YES	NO	N/A
Mobile #: (____) ____________________	YES	NO	N/A
Work #: (____) ____________________	YES	NO	N/A
Would you like to receive Text Messages?	YES	NO	N/A

Emergency Contact Information:

May we Discuss your Health Care Information with the Person Listed Below? YES

First	M.I.	Last	Relationship	Contact #

Please list any medical providers you would like to authorize to have access to your medical records. These records will only be released upon your verbal request. You may revoke this authorization in writing at any time. By completing this section, you are authorizing Goodless Dermatology to release your medical record (including laboratory test results) to the provider(s) listed.

Primary Care Physician: ______________________ Phone #: ______________________
Address: ______________________ Fax #: ______________________
Other Physician: ______________________ Phone #: ______________________
Address: ______________________ Fax #: ______________________

Were you referred to our office by a physician? YES / NO

If yes, Referring Physician: ______________________ Phone #: ______________________
Address: ______________________ Fax #: ______________________

410 Celebration Place Suite 301
Celebration, FL 34747
tel 407.566.1616
fax 407.566.1617

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Today's Date: ______________________________

Patien'ts Name: ______________________________ **Date of Birth:** ____________________

Affordable Healthcare Act Questionnaire:

Race (Please Circle Only One)

I choose not to specify   American Indian/Alaskan Native   Asian   White/Caucasian

Native Hawaiian/Other Pacific Island   Black/African American   Other: ____________________

Ethnicity (Please Circle Only One)

I choose not to specify   Not Hispanic or Latino   Hispanic or Latino

Preferred Language (Please Circle Only One)

I choose not to specify   English   Spanish   American Sign Language   Other: __________

Privacy Acknowledgment:

__________ Initials

We are required to protect your privacy
Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is available on our website and/or is furnished.

__________ Initials

We request all patients present a valid photo ID at each visit, unless we have it on file.
Your cooperation with HIPAA requirement is designed to protect your identity from misuse.

__________ Initials

Patients may revoke or change any provided authorizations at any time.
Please refer to our NPP for more details.

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Today's Date: ______________________

Patien'ts Name: ______________________ Date of Birth: ______________________

Medications: Please list all current medications with all the requested information
(If you do not take any medications please write NONE)

Medication Name	Strength	How many times a day?

Allergies: Please list all allergies to medications and the reaction you have
(If you do not have any allergies to drugs, please write NONE)

Medication Name	Reaction to Medication

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Today's Date: ______________________________

Patien'ts Name: ______________________________ Date of Birth: ____________________

Social History:

Smoking Status: (Please Circle One) Current smoker Former smoker Never smoked

Alcohol: Please answer the following

Men: How many times in the past year, have you had 5 or more drinks in a day? __________

Women: How many times in the past year, have you had 4 or more drinks in a day? ________

Have you received an influenza immunization? **YES** **NO**

Please answer the following if you are 65 years of age or older.

Have you received a Pneumonia vaccination? **YES** **NO**

Do You Have Any of the Following? If you do not, please circle none:

Please furnish a copy of legal documents to Goodless Dermatology, if necessary.

A Health Care Proxy Living Will (Advance Care Plan) None

Health care proxy name and contact #: ____

Which statement best reflects your wishes on advanced care recommendations?

Please select one of the following:

Full Code: I wish to have full cardiopulmonary resuscitation efforts to be made.

Do Not Intubate:
I do NOT wish to have a breathing tube, even if it is required for life saving measures.

Do Not Resuscitate:
In the event that my heart was to stop, I do NOT wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is required for life saving measures.

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