PATIENT REGISTRATION FORM

Name: _____ *(*_____*)Jr /Sr*
First Middle Last (how you wish to be addressed)

Local Address: _____
Street City State Zip Code

Other Address: _____
Street City State Zip Code

*Home Phone: ( )*_____ *Work Phone: ( )* _____

*Cell Phone: ( )*_____

Social Security #: _____ *Employer:* _____

Date of Birth: _____ *Age:* _____ *Sex:* ___ *M* ___ *F* *Name of Spouse or Parent:* _____

Do we have your permission to:

Leave a message on your answering machine at home? *Y* _____ *N* _____
Leave a message at your place of employment? *Y* _____ *N* _____
Discuss your medical condition with any member of your household? *Y* _____ *N* _____

If yes, whom: *Relationship* _____
Relationship _____

- **PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR COPAY AND DEDUCTIBLE.**
- For insurances that we participate with, a claim will be submitted to your insurance company. If payment is not received from the insurance company within 60 days, the account balance will be your responsibility.
- **SELF-PAY PATIENTS ARE REQUIRED TO PAY 100% AT THE TIME OF SERVICE.**
- You will be given a universal claim form to submit to your insurance at checkout.
- Visa, Mastercard and Discover are accepted.
- In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial polices of this office.
- All returned checks are subject to a $30 handling fee.

I understand the above policy.

_____
Signature Date

I hereby authorize Daniel King, MD to request medical records, pathology reports and laboratory reports from any physician, hospital, or clinic where I have been treated. I also authorize Daniel King, MD to release any medical records, pathology reports, and laboratory reports to any physician, hospital or clinic if requested. I authorize the release of my medical records or other information necessary to process an insurance claim.

_____
Signature Date

We want you to know that, if you pass out, are disoriented or we feel it is an emergency we will call 911. This is for your safety.

By signing below I acknowledge I have read and agree with the above:

_____
Signature Date

Daniel King, MD
Dermatology Associates of the Treasure Coast
809 East Osceola Street • Stuart, FL • 34994
Phone: 772 219 0044 FAX: 772 219 0709

What is your main skin concern? Accompanied by: Date:

Where is the area of concern?
How long have you had the problem?
Is the problem getting worse? N/Y
Does it itch? N/Y
Does it hurt? N/Y
How bad is the problem(circle one)? mild moderate severe
How often is it a problem? daily weekly constant
What have you done for it?

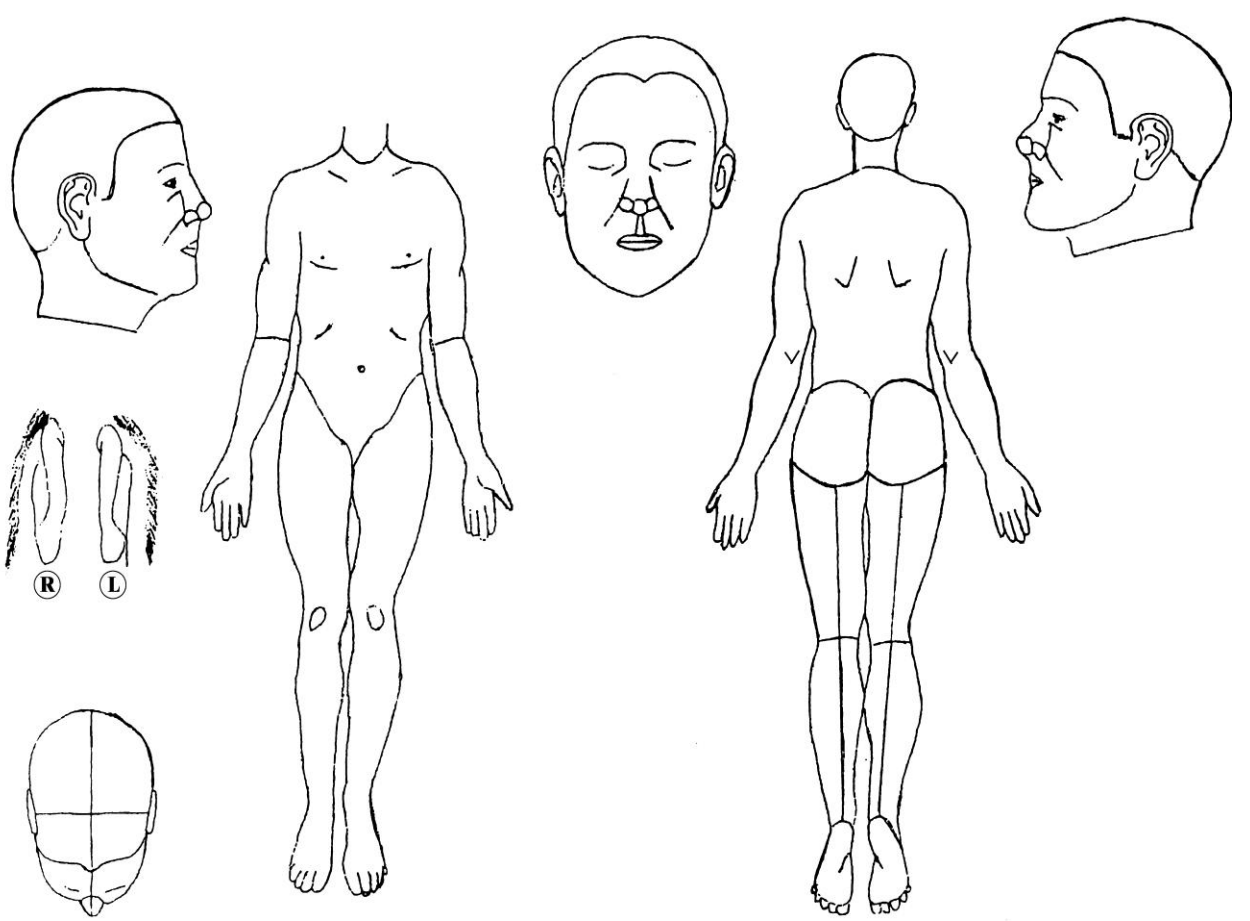
List any other problems to be addressed:

Are any other areas of your body affected by your concerns?

Are there any lesions on your skin or in your mouth that are changing, hurting, itching, or bleeding? N/Y/NA
Do you have any of the following: bleed easily y/n, forgetfulness y/n, form thick scars y/n, heal poorly y/n, swollen glands y/n
Have you ever had a skin cancer? N/Y-type/location:

A full skin exam is recommended for skin cancer detection, do you want one? Y/N INT___

OFFICE USE: B/P P no acute distress healthy, frail alert, oriented(person, place, time), inappropriate, uncommunicative pleasant,flat,upset well nourished,thin,overweight makeup tanned



E1full
1upper

Acne
Aldara Sc
Aldara wart
CyroA
Cyst
Dysplstc
Efudex
Efud/Aldara Sc
Fungus/Int
Hair care
Hair question
Hand eczema
Insect
Isotretinoin
Meds
MM/ABCDE
Nail
OTC
PDT
Perirectal
Photograph
Pred
Psoriasis
Rosacea
Scabies
Shaving
Shingles
Scr/Sunsafety
Sginstr
SkinCaRx Opt
Staph h/o
Taper
Urt:AAD
WmCmpr
Wtreat
Wtreatopt
Wound Care

No dictation
Not seen
Seen

Self exam advised

1w 2w 3w 1m 6w 2m 3m 4m 6m 12m 30min, 40min, 60min 75min
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
_____ I scribed for Dr. King/Sally Ritter, ARNP F/U w/ Dr. King / Sally Ritter, ARNP / MA

Dermatology Associates of the Treasure Coast
809 East Osceola Street
Stuart, FL 34994

Affix label here

Allergies: Lidocaine, Epinephrine, Latex, Adhesives, Hibiclens (Chlorohexidine), Clindamycin, or Iodine: Y / N
Pacemaker: Y / N

I understand that it is important for my medical providers to have as much information about my health history as possible and I have done my best to give a complete medical history. I can speak, read and write English.

I hereby authorize the performance upon myself or _____ (name of patient) the following circled procedure (s) by Dr. King or Sally Ritter, ARNP or Cindy A. Kirkpatrick, RN, DNC

1) **Biopsy of the skin**: This involves taking a skin sample. It may or may not have sutures. The lesion may or may not be completely removed.

2) **Removal of a lesion**: This involves cutting or scraping a lesion off. The wound heals in an open fashion.

3) **Excision of a lesion**: This involves cutting out a section of skin and typically suturing the wound closed.

4) **Incision and drainage of abscess**: This involves cutting open and draining a cyst/boil and either packing or leaving the lesion to heal by secondary intention.

I have been made aware by Dr. King or Sally Ritter, ARNP there are risks to surgical procedures such as: damage to nerves, blood vessels, allergic reactions, bleeding, infection, pain, numbness, and objectionable scars. Scars always result from these procedures and a second procedure is sometimes necessary to improve a scar or definitively treat a lesion. These procedures are done with local anesthesia (numbing the skin with lidocaine) in the office.

I have been informed to my satisfaction about the procedure being performed on the date listed below, why it is necessary, alternative treatments, the risks to my health if the condition remains untreated and what the procedure entails.

I acknowledge that no guarantee or assurance has been given by anyone as to the results, which may be obtained. I realize it is my responsibility to keep my post-operative appointment. If I feel any problems exist such as bleeding, infections, or if I have any doubts, I am to contact Dr. King or his designee(s). I consent to the disposal by the physician's staff of any tissues or body parts that may be removed. I acknowledge that all blank statements on this document have been either completed or crossed off prior to my signing.

For the purpose of education or documentation, I consent to photographing of my skin. The photographs may be published or presented to educate patients, physicians or the community.

SIGN ONLY IF YOU HAVE READ THE ABOVE

Date _____ Signed _____ Witness_____ Physician/NP/RN_____

☐ Copy given to patient ☐ Pt defers copy

 This office is regulated pursuant to the rules of the Florida Board of Medicine as set forth in Chapter 64B8 Florida Administrative Code.

Medication List

Including ALL Vitamins and Herbs

(*Affix Label)*

Date	Medication	Start Date	Stop Date	Comments

Dermatology Associates of the Treasure Coast, PA

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of Dermatology Associates of the Treasure Coast, PA's Notice of

Privacy Practices.

_____ _____
Signature of Patient Date

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