Porter Premiere Dermatology
& Surgery Center
New Patient History and Intake Form

Date: ____/____/_____

Patient Name: _____ **Patient DOB:** ____/____/____

Patient Email Address: _____

Primary Care Physician: _____ **Phone #** _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy

Past Surgical History: (Cont.)

Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other_____

_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family medical history: _____
_____

Medications: (Please enter all current medications)

_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Illicit Drug Use:
- Drug Use
- IV Drug Use

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:
- I feel safe at home.
- I do not feel safe at home.

Other_____

Pharmacy Information

Please list the name and location of the pharmacy where you do business

Pharmacy Name: _____
Pharmacy Location: _____
Pharmacy Telephone Number: _____

Alerts: Please indicate if the following Alerts apply to you. (check yes or no)

Alert	Yes	No
Pacemaker		
Defibrillator		
Artificial joints within past two years		
Artificial heart valves		
Require premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Currently pregnant or planning a pregnancy		
Allergy to lidocaine		
Allergy to marcaine		
Rapid heartbeat to epinephrine		
Yeast infections to antibiotics		
GI upset with antibiotics		

Other Alerts/Symptoms: _____

_____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

_____

Phone: _____

EXHIBIT 1
Revised April 1, 2012
WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Porter Premiere Dermatology

I, _____, have (1) received a copy of the Notice of the Privacy
Patient Name

Practices or
(2) has been offered a copy of the Notice of the Privacy Practices but declined to accept a copy.

_____ _____
Signature of Patient Date

WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the ___ day of _____, 2012, the Notice of Privacy Practices was

_____offered and/or given to _____.
Patient Name

____ The Patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

____ The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

_____ _____
Signature of Employee Date
who offered the Patient the Notice

Porter Premiere Dermatology and Surgery Center & Premiere Medical Aesthetics

Patient Authorization for Use of Protected Health Information for Purposes Other Than Those Disclosed in the Notice of Privacy Practices

By signing this authorization, I authorize Porter Premiere Dermatology and Surgery Center & Premiere Medical Aesthetics to use certain protected health information (PHI) about me for purposes of informing me of events, special offerings, cosmetic services, skin care products or aesthetic services that may be of interest to me.
In addition to those uses and disclosures delineated in our Notice of Privacy Practices, this authorization specifically permits Porter Premiere Dermatology and Surgery Center & Premiere Medical Aesthetics to use the following individually identifiable health information about me for purposes listed above:

- Diagnosis
- Previous treatment records
- Demographic
- E-mail address
- Phone number

It has been explained to me that I do not have to sign this authorization; it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Privacy Officer, Porter Premiere Dermatology and Surgery Center & Premiere Medical Aesthetics, 1344 S. Apollo Blvd., Suite 300, Melbourne, Fl 32901.

This authorization will expire on _____
{Expiration Date or Defined Event}

_____ _____
Patient Signature Date

_____
Print Patient Name

PATIENT / GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION