APEX SKIN
MEDICAL / SURGICAL / AESTHETIC

How did you find us?

- ☐ Family/Friend - Name: _____
- ☐ Insurance Provider List:
- ☐ Internet Search
- ☐ Newspaper Ad
- ☐ Physician - Name: _____
- ☐ Yellow Pages
- ☐ Other: _____

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____ ☐ Male ☐ Female

Preferred Name: _____
("John","Mr. Jones", etc.)

Patient Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SS# _____ ☐ Legally Separated ☐ Partner

Mailing Address: _____

City: _____ State: _____ Zip: _____
(If PO Box, complete Street Address below)

Street Address: _____

City: _____ State: _____ Zip: _____
(Complete only if Mailing Address provided above is a PO Box)

Email: _____

Preferred Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other: _____

Alternate Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other: _____

PCP/Family Doctor: _____

Referring Doctor: _____

Do you have an advance directive (Living Will or HealthCare Power of Attorney) regarding your healthcare wishes? ☐ Yes ☐ No

SEND PATIENT STATEMENTS TO:

Name: _____ Relation: _____

Address: _____
(If different from patient's)

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION ☐ SELF PAY

Primary	Secondary
Insurance: _____	Insurance: _____
ID#: _____	ID#: _____
Policy Holder:	Policy Holder
Patient *(If not patient, complete information below)*	Patient *(If not patient, complete information below)*
Name: _____	Name: _____
DOB: _____ SS#: _____	DOB: _____ SS#: _____
Relation: _____	Relation: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____

Does your insurance plan require you to have a referral to see a specialist? ☐ No ☐ Yes ☐ I don't know
NOTE: It is the patient's responsibility to get any required referrals.

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CONTACT IN CASE OF EMERGENCY:

Name: _____

Phone #(s): _____ Relationship: _____

MEDICAL RELEASE: *Please list any persons to whom your protected health information can be disclosed (e.g., spouse. parent, etc):*

Name: _____

Phone #(s): _____ Relationship: _____

Name: _____

Phone #(s): _____ Relationship: _____

Occupation: _____ Employer/Company: _____

SPOT CHECK PATIENTS ONLY:

I UNDERSTAND THAT TODAY'S VISIT IS A LIMITED EXAM SPECIFIC TO ONE SPOT OF CONCERN. _____
Pt. Initials

NO SHOW AND CANCELLATION POLICY:

We understand that situations arise that may require you to cancel your scheduled appointment. As a courtesy to other patients and our medical staff, we require that you provide our office with a minimum of 24 hours' notice of cancellation.

Patients who fail to keep their scheduled appointment and who do not provide 24-hour notice of cancellation will be considered as NO SHOW. Patients who have two (2) documented NO SHOW appointments will only be able to schedule "SAME DAY" appts for all services with Apex Dermatology providers and staff for a six (6) month period from the date of the last NO SHOW appointment.

SIGNATURE *(Patient or Guardian)* _____ **DATE** _____

COMPLETE PAGE 3 OF THIS FORM FOR MEDICAL HISTORY

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MEDICAL HISTORY

Patient:_____ **DOB:** __/__/__ **Reason for visit:**_____ **Appointment Date:** __/__/__

Did a doctor's office send you to us for a specific problem? ☐ Yes ☐ No ☐ If YES, name of referring provider: _____

List any medications, herbal supplements and/or vitamins you are currently taking: ☐ Not taking any medications

_____ _____ _____

_____ _____ _____

Have you had the flu vaccine? ☐ **Yes** ☐ **No** If YES, when? _____

Have you had the pneumonia vaccine? *(patients over 55 years old)* ☐ **Yes** ☐ **No** If YES, when? _____

Do you have or have you had any of the following? *(If yes, please check)* ☐ None

- ☐ Acne
- ☐ Artificial heart valve
- ☐ Artificial joints or metal implant
- ☐ Atopic Dermatitis
- ☐ Atypical moles
- ☐ Autoimmune disease (lupus, rheumatoid arthritis)
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Cold sores/herpes
- ☐ Depression
- ☐ Diabetes
- ☐ Heartburn/Reflux
- ☐ HIV
- ☐ High blood pressure/Hypertension
- ☐ Keloids or scarring problems Kidney
- ☐ disease
- ☐ Liver disease or hepatitis
- ☐ Lung disease
- ☐ Psoriasis
- ☐ Seasonal allergies/asthma
- ☐ Skin Cancer
- ☐ Skin Pre-Cancers (actinic keratoses)
- ☐ Thyroid trouble
- ☐ Ulcers (stomach)
- ☐ Other conditions

Please list: _____

Female patients *(check all that apply):* I am ☐ pregnant ☐ nursing ☐ planning to become pregnant in the near future

Are you allergic to any medications/anesthetics? ☐ Yes ☐ No
(If yes, please list)

_____ _____ _____

Please list major surgeries/hospitalizations:

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

Please list IMMEDIATE FAMILY that have had any of the following: *(mother, father, maternal or paternal grandmother or grandfather, brother, sister)*

Skin Cancer-Melanoma: _____ Psoriasis: _____

Skin Cancer-Other: _____ Eczema: _____

Other Cancers: _____ Other: _____

Does your insurance require a specific Lab? ☐ Yes ☐ No Name of preferred Laboratory: _____

May we leave a message on your answering machine/voicemail? ☐ Yes ☐ No

Preferred Pharmacy: _____ Phone: _____

Smoking Status:
☐ Never ☐ Former ☐ Current Daily ☐ Current Occasional

Do you use smokeless tobacco? ☐ Yes ☐ No

Drink alcoholic beverages? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you use sunscreen on a daily basis? ☐ Yes ☐ No

Have you traveled outside the U.S. in the past 3 months? ☐ Yes ☐ No

Have you had at least one blistering sunburn? ☐ Yes ☐ No

Have you ever used a tanning bed? ☐ Yes ☐ No

Do you currently use a tanning bed? ☐ Yes ☐ No

Have you RECENTLY had any of the following? *(Please check all that apply)* ☐ None

- ☐ Headache/Fatigue
- ☐ Swollen glands/Rash
- ☐ Fever/chills/wt. change
- ☐ Sun sensitivity
- ☐ Itching
- ☐ Muscle Aches
- ☐ Joint Aches
- ☐ Ringing in ears

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CONSENT FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND PERFORMANCE OF SURGERY AND/OR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY

1. I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intra-lesional kenalog (cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by Jorge Garcia-Zuazaga, MD, or by any physician, nurse practitioner, physician assistant, or appropriately trained and/or licensed health care personnel on the staff of Apex Dermatology and Skin Surgery Center, for or upon me or my minor child.

2. I further consent to the examination for diagnostic and/or investigational purposes, and the disposal, by the authorities of the above named medical facility or its designates herein, of any tissue or parts which may be removed.

3. I understand that the skin biopsy involves removal of a piece of skin, and that such removal may result in a permanent scar or in discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.

4. I understand that all specimens removed are sent for dermatopathologic analysis and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all the charges as determined by my insurance carrier.

5. I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses, may be deemed necessary by a member of the medical staff, to prevent the risk that these lesions evolving into squamous cell carcinomas (skin cancer).

6. I understand that the destruction by liquid nitrogen of warts or Mollusca may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they should be treated. Should Dr. Jorge Garcia-Zuazaga or a member of the Apex medical staff recommend destruction of these lesions by liquid nitrogen, I consent based on that advice. I am aware that these lesions may require more than a single treatment.

7. I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable, or desirable by Dr. Jorge Garcia-Zuazaga or a member of the Apex medical staff.

8. I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to, permanent scarring, permanent discoloration of the skin at the treatment site, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

9. I understand that no guarantees or assurances have been made as to the effectiveness of treatments or procedures which I may receive from Dr. Jorge Garcia-Zuazaga or a member of the Apex medical staff. I acknowledge that no guarantees or assurances have been made to me concerning the results of treatments and/or procedures.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD, AND RECEIVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLANANTONS REGARDING THE PROVIDED INFORMATION.

Signature of Patient_____ Date: _____

If patient is under 18 years of age or unable to authorize consent.
Signature of Parent or Legal Guardian _____Date: _____

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APEX DERMATOLOGY
PATIENT INFORMATION PACKET

The documents listed below are provided to patients in the normal course of business for Apex Dermatology, and I have been informed that additional copies and/or updates will be provided to me at my request.

I have received, read, and understand the following documents:

1. Consent for Medical Treatment, Administration or Local Anesthesia and Performance of Surgery and/or Procedures Necessary to the Practice of Dermatology
2. Insurance Coverage and Our Patient Form
3. Notice of Privacy Practices.

_____ _____
Signature of Patient Date

If the patient is under the age of 18 years or unable to provide authorization

_____ _____
Signature of Parent or Legal Guardian Date