

# COASTAL DERMATOLOGY, PA

2804 ST. JOHNS BLUFF RD S, STE 109

JACKSONVILLE, FLORIDA 32246

PHONE: (904) 727-9123

FAX NO: (904) 855-4255

183 LANDRUM LANE STE 201

PONTE VEDRA BEACH, FL 32082

PHONE: (904) 567-1050

FAX NO: (904) 567-1051

PATIENT NAME: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

PHARMACY: \_\_\_\_\_

APPROXIMATE HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

HAVE YOU HAD THE FLU VACCINE \_\_\_\_\_

HAVE YOU HAD THE PNEUMOCOCCAL VACCINE \_\_\_\_\_

HAVE YOU HAD THE SHINGRIX VACCINE \_\_\_\_\_

DO YOU SMOKE \_\_\_\_\_ DRINK ALCOHOL \_\_\_\_\_

IF YES, HOW MANY DRINKS DAILY \_\_\_\_\_ WEEKLY \_\_\_\_\_

HAVE YOU CONSUMED 5+ DRINKS IN ONE DAY IN THE PAST YEAR \_\_\_\_\_

DO YOU HAVE AN ADVANCE DIRECTIVE CARE PLAN \_\_\_\_\_ YES/NO

EMAIL ADDRESS: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

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Welcome to our practice. Please complete the following forms. Please **PRINT** all information. Thank you.

PRIMARY LANGUAGE: \_\_\_\_\_ RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE INITIAL)

CHECK ONE: SEX M \_\_\_ F \_\_\_ MARRIED: \_\_\_\_\_ SINGLE: \_\_\_\_\_ WIDOWED: \_\_\_\_\_ DIVORCED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NO: \_\_\_\_\_

PATIENTS ADDRESS: \_\_\_\_\_  
STREET ADDRESS/APARTMENT NUMBER

(CITY) (STATE) (ZIP)

HOME TELEPHONE NO: \_\_\_\_\_ MOBILE PHONE NO: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

NAME & PHONE NUMBER OF EMERGENCY CONTACT: \_\_\_\_\_

IF UNDER 18, PARENT/GUARDIAN NAME AND PHONE NO: \_\_\_\_\_

EMAIL ADDRESS (FOR PATIENT PORTAL): \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
NAME AND PHONE NUMBER

REFERRED BY: \_\_\_\_\_ PHARMACY NAME & NO: \_\_\_\_\_

## **INSURANCE INFORMATION**

For your protection, patients(s) and/or legal guardian must provide a valid photo identification card along with appropriate Insurance cards. We hope you understand we cannot make exceptions.

\_\_\_\_\_ CHECK HERE IF YOU DO NOT HAVE INSURANCE OR DO NOT PLAN TO USE YOUR INSURANCE BENEFITS.

PRIMARY INSURANCE \_\_\_\_\_ POLICY ID: \_\_\_\_\_

GROUP# \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_ SOC. SEC# \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ POLICY ID: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_ SOC. SEC# \_\_\_\_\_

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## MEDICAL HISTORY

1. Reason for today's visit: \_\_\_\_\_

2. Medical History (Include any prior or current medical problems, serious illnesses or injuries, operations, skin problems or skin cancers.

3. Family History include any illnesses or diseases including skin problems or skin cancers.

4. Please list all medications including non prescription drugs that you take regularly:

5. Please list known drug allergies or reactions you may have had to any medications:

6. Please provide any additional information you feel may be helpful to us:

7. Would you like information or any of the following?

- \_\_\_\_\_ Treatment of sun damaged skin
- \_\_\_\_\_ Improving skin texture and tone or removal of unwanted hair
- \_\_\_\_\_ Personalized skin care regiment/Physician Grade Products
- \_\_\_\_\_ Reduction of fine/deep lines & wrinkles
- \_\_\_\_\_ Botox
- \_\_\_\_\_ Fillers (Juvederm, Sculptra, Radiesse)
- \_\_\_\_\_ Physician grade facials or chemical peel
- \_\_\_\_\_ Vaser Liposelection (body contouring)
- \_\_\_\_\_ Acne Scarring
- \_\_\_\_\_ Lasers

Printed Name

Date

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## Acknowledgements/Authorizations:

- In the event that it is necessary to cancel or reschedule your appointment, we ask that you notify us at least 24 hours before your scheduled appointment. This allows us to make that time available for another patient. If we receive inadequate notice or you miss the appointment, you may be charged a missed exam/surgery fee.
- If a personal or business check is issued by you or at your behalf is returned unpaid for any reason by the financial institution, an additional fee as determined by vendor policy or Florida Statute will be added to the amount owed. **STATEMENT OF FINANCIAL RESPONSIBILITY**
- I acknowledge I am financially responsible for all charges for services provided to me, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, an HMO or any other payer. I also acknowledge that if I fail to pay for services provided and not paid by any health care plan(s), my account may be forwarded for collection and I will also be responsible for any collection related charges and that information will be reported to credit reporting agencies. Additionally, I acknowledge Coastal Dermatology will not submit claims to my health insurance carrier for services deemed cosmetic.
- I authorize Coastal Dermatology, PA to release all medical information necessary to all insurance carriers or any other payers; person(s) I have designated as guarantor for the billing, payment and coverage for my account any other health care providers for treatment purposes.
- I authorize my insurance carrier, health plan administrator or any other payer to pay directly to Coastal Dermatology any benefits due under the terms of my health care plan(s) for services provided by same. I understand Coastal Dermatology reserves the right to refuse or accept assignment of medical benefits. If my plan will not allow direct payment to Coastal Dermatology or if the provider chooses not to accept assignment, I agree to immediately forward all health care payments I receive for those services provided by Coastal Dermatology. I authorize Coastal Dermatology to contact my insurance carrier, health plan administrator, other payer or review agencies to obtain all pertinent benefit and financial information concerning coverage and payments made under my health plan. I further authorize my insurance carrier, health plan administrator, and any other payer, agents or review agencies to release such information to Coastal Dermatology.

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Patient/Guarantor Signature

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Date

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Printed Name

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Attention Patients!!! We are updating our method of contact for your appointment reminders, we are now sending text message and email reminders for up-coming appointments!! Please provide your most current cell phone number and e-mail address

Thank you,

Coastal Dermatology

**PATIENT NAME AND DOB:** \_\_\_\_\_

**PLEASE CHECK ONE:**

☐ **I WOULD LIKE TEXT MESSAGE REMINDERS.**

CELL PHONE # \_\_\_\_\_

☐ **I WOULD LIKE EMAIL REMINDERS.**

EMAIL ADDRESS: \_\_\_\_\_

☐ **I DO NOT WISH TO HAVE EITHER. PLEASE JUST CALL.**

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## PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI) THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME.

### I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

\_\_\_\_ HOME PH: \_\_\_\_\_

\_\_\_\_ O.K. to leave message with detailed information

\_\_\_\_ Leave Message with call back number only

\_\_\_\_ Work Ph: \_\_\_\_\_

\_\_\_\_ O.K. to leave message with detailed information

\_\_\_\_ Leave Message with call back number only

\_\_\_\_ Written Communication

\_\_\_\_ O.K. to mail to home address

\_\_\_\_ O.K. to mail to work address

\_\_\_\_ O.K. to fax to this number: \_\_\_\_\_

I authorize Coastal Dermatology PA to discuss my PHI with the following individual

\_\_\_\_\_  
Name of Authorized Individual

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

# COASTAL DERMATOLOGY, PA

Receipt of Notice of Privacy Practices Written Acknowledgement Form:

I am a patient of COASTAL DERMATOLOGY & Medspa. I hereby acknowledge receipt of the Coastal Dermatology & Medspa's Notice of privacy Practice.

Name and Date of Birth: (please print)\_\_\_\_\_

Signature:\_\_\_\_\_

Date:\_\_\_\_\_

Or

I am a patient or legal guardian of \_\_\_\_\_ (patient name). I hereby acknowledge receipt of COASTAL DERMATOLOGY & Medspa's Notice of Privacy Practices with respect to the patient.

Name: (please print)\_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Parent      \_\_\_\_\_ Legal Guardian

Signature:\_\_\_\_\_

Date:\_\_\_\_\_