Welcome to Venice Avenue Dermatology!

Please fill out the information below. You may complete this information online at our patient portal, http://www.premierdermdocs.ema.md. You may call us at **(941) 486-1404**, at any time and we will provide you with your personal access information. You can also mail or fax your completed forms to:

Venice Avenue Dermatology, 897 East Venice Avenue, Suite A., Venice, FL 34285 – Fax: (941) 486-4146

NOTE: If you have an HMO plan, you are responsible for obtaining an Authorization from your primary care physician prior to your visit or we may have to reschedule your appointment.

PATIENT INFORMATION

Patient Name: *(First/Middle/Last)*	**Date of Birth:** *(mm/dd/yy)*	**Gender:** ☐ Male ☐ Female	**Social Security #:**
Preferred Name:_____ *(ex: John, Johnny, Mr. Smith, Dr. Smith)*	**Ethnicity:** ☐White ☐Black/African American ☐Asian ☐Other ☐American Indian/Alaskan ☐Hawaiian/Pacific Islander		
Local Address:	**Email:**		
City/State/Zip:	**Home Phone #:**	**Mobile Phone #:**	
Alternate Address: *(If applicable)*	**Emergency Contact:**		
City/State/Zip:			
Primary Care Physician:	**Relationship:**	**Phone #:**	
Did a Healthcare Provider refer you to us? ☐Yes ☐No **If yes, Name:**	**How did you hear about us?** ☐Website/Internet ☐Newspaper ☐Doctor ☐Friend/Family ☐Insurance Plan ☐Other _____		

Receipt of Notice of Privacy Practices

Your privacy is important to us. The information that we record about you and your medical history is to help us provide quality medical care. We are committed to protecting this information. The Notice of Privacy Practice describes your rights with regards to your health information and our responsibility to protect that information. **A complete copy of our Notice of Privacy Practices is available for you in our lobby. Additional copies are available for you to take home**.

Your Rights Include:

- ⇨The right to amend your health information
- ⇨The right to request restrictions on what information we use or know we disclose your health information
- ⇨The right to see an account of certain disclosures we have made of your health information
- ⇨The right to obtain access to your health information with limited exceptions (written request, advance notice and a cost-based fee for expenses delineated by law)
- ⇨The right to receive a paper copy of our Notice of Privacy Practices

These rights do have certain restrictions and you may obtain detailed disclosure of these restrictions at any time. My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Personal Health Information. **Copy provided upon request.*

Signature: _____ Name:_____ Date:_____

Venice Avenue Dermatology - Patient Medical History

Patient Name: *(First/Middle/Last)* | **Date of Birth:** *(mm/dd/yy)*

Primary Care Physician: | **Known Drug Allergies:**

Current Prescriptions AND Over The Counter Medications:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Select any of the following medical conditions you currently have:

- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Prostate)/Prostate Cancer
- ☐ Cancer: Breast, Colon, Kidney, Lung
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure (Hypertension)
- ☐ HIV/AIDS
- ☐ High Cholesterol (Hypercholesterolemia)
- ☐ Hyper/Hypothyroidism
- ☐ Leukemia/Lymphoma
- ☐ Radiation Treatment: ☐ Current ☐ Past
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

Have you had any of the following surgeries?:

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Biopsy/Lumpectomy/Mastectomy
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon: Inflamatory Bowel Disease/Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Bypass Surgery/Valve Replacement
- ☐ Joint Replacement: Knee (☐ Left/☐ Right)
- ☐ Joint Replacement: Hip (☐ Left/☐ Right)
- ☐ Kidney: Kidney Biopsy/Nephrectomy
- ☐ Ovaries: Endometriosis/Cysts/Cancer
- ☐ Ovaries: tubal LIgation/Hysterectomy
- ☐ Prostate: Biopsy/TURP
- ☐ Spleen (Splenectomy)
- ☐ Transplant: Heart/Kidney/Liver/Lung
- ☐ Testicles (Orchiectomy)
- ☐ Uterus: Uterine or Cervical Cancer
- ☐ Other _____

Do you currently, or have formerly suffered(ed) from any of the following skin conditions?:

- ☐ Acne
- ☐ Actinic Keratoses (Pre Cancers)
- ☐ Basal Cell/ ☐ Squamous Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Eczema/ ☐ Psoriasis
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Other _____

Do you have any of the following? (Please check all that apply):

- ☐ Allergy to lidocaine/Epinephrine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial joints within past 2 years
- ☐ Defibrillator/ ☐ Pacemaker
- ☐ Pregnancy or planning a pregnancy
- ☐ Allergy to adhesive or latex
- ☐ Artificial heart valve
- ☐ Blood thinners
- ☐ Premedication prior to procedures

Social History Details:

Do you currently smoke cigarettes?
☐ YES ☐ NO

Have you ever smoked cigarettes?
☐ YES ☐ NO

Do you drink alcohol?
☐ YES ☐ NO

Number of drinks per day:
_____

Family History:

Positive family history of MELANOMA?
☐ YES ☐ NO

If yes, which relative(s)?
_____

Do you tan in a tanning salon?
☐ **YES** ☐ **NO**

Do you wear sunscreen?
☐ **YES** ☐ **NO**

Pharmacy Name and location:
_____

Occupation/Hobbies:
_____

_____