

DERMATOLOGY ASSOCIATES
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PATIENT INFORMATION

Name _____
First MI Last

Sex M F Date of Birth _____
Month Day Year

Social Security # _____ Marital Status Single / Married / Widow / Divorced

Mailing Address _____

City State Zip Email _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other _____

Employer _____

Employer Address _____
City State Zip

Job Title _____

PRIMARY INSURANCE YES / NONE

Type _____

Policy # _____ Group # _____

Guarantor _____
First MI Last

Relation to Patient _____ DOB _____

SECONDARY INSURANCE YES / NONE

Type _____

Policy # _____ Group # _____

Guarantor _____
First MI Last

Relation to Patient _____ DOB _____

RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)

Name _____
First MI Last

Sex M F Date of Birth _____
Month Day Year

Social Security # _____

Mailing Address _____

City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ Other _____

I authorize Dermatology Associates to charge outstanding balances on my account to the following credit card:

Visa Mastercard American Express Other: _____

Account Number _____ Expiration Date _____

Name on card (please print) _____

Signature _____ Date _____

DERMATOLOGY ASSOCIATES

PATIENT HISTORY

Patient's Name _____ Date of Birth _____

Medication Allergies _____

Present Medications _____

Family Doctor _____ Referred By _____

DO YOU OR HAVE YOU EVER HAD

Asthma _____ High Blood Pressure _____ Hayfever _____ Diabetes _____

HIV/AIDS _____ Heart Trouble _____ Hepatitis _____ Ulcers _____

Arthritis _____ Glaucoma _____ Tuberculosis _____

Diagnosed Cancer _____ What Kind/Where _____

Diagnosed Skin Cancer _____ What Kind/Where _____

HAVE YOU HAD THE FOLLOWING SURGERIES

Gallbladder _____ Hysterectomy _____ Appendectomy _____ Hernia _____

Tonsillectomy _____ Adenoidectomy _____ Thyroidectomy _____ Prostrate _____

Knee Replacement _____ Hip Replacement _____

Please list any surgeries not listed above _____

FAMILY HISTORY (circle one)

Diabetes _____ Mother / Father _____ Asthma _____ Mother / Father _____

Hayfever _____ Mother / Father _____

Melanoma _____ Mother / Father _____ What Kind / Where _____

Diagnosed Skin Disease _____ Mother / Father _____ What Kind / Where _____

PLEASE ANSWER THE FOLLOWING

Do we have permission to mail any information to your mailing address?

Yes or No

Do we have permission to leave a message on your answering machine?

Yes or No

Please list any person(s) that we may contact regarding any treatment, payment or any healthcare operation

I give my consent to Dermatology Associates that they may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology Associate's Notice of Privacy Practices for a more complete description of such uses and disclosures.

Patient/Legal Guardian's Signature Date

Patient Financial Responsibility

I understand and agree to pay for all charges incurred regardless of insurance coverage. I hereby authorize my insurance carrier to pay and assign all medical and/or surgical benefits to Dermatology Associates.

Patient/Legal Guardian's Signature Date