

Intake Form Page 1

Name _____ Primary Care Physician: _____

Date of Birth _____ Pharmacy: _____

Known Drug Allergies: _____

Current prescriptions AND over the counter medications:

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

Select any of the following medical conditions that you currently have

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

Have you had any surgeries on the following?

- | | |
|--|---|
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Kidney: Kidney Biopsy/ Nephrectomy |
| <input type="checkbox"/> Bladder (Cystectomy) | <input type="checkbox"/> Ovaries: Endometriosis/ Cysts/ Cancer |
| <input type="checkbox"/> Breast: Biopsy/ Lumpectomy/ Mastectomy | <input type="checkbox"/> Ovaries: Tubal Ligation/ Hysterectomy |
| <input type="checkbox"/> Colon (Colectomy): Colon Cancer Resection | <input type="checkbox"/> Prostate: Biopsy/ TURP |
| <input type="checkbox"/> Colon: Inflam. Bowel Disease/ Colostomy | <input type="checkbox"/> Spleen (Splenectomy) |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Transplant: Heart/ Kidney/ Liver/ Lung |
| <input type="checkbox"/> Heart: Bypass Surgery/ Valve Replacement | <input type="checkbox"/> Testicles (Orchiectomy) |
| <input type="checkbox"/> Joint Replacement: Knee (Left/Right) | <input type="checkbox"/> Uterus: Uterine or Cervical Cancer |
| <input type="checkbox"/> Joint Replacement: Hip (Left/Right) | <input type="checkbox"/> Other _____ |

Have you had any of the following skin conditions?

- | | |
|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaking or Itchy Scalp |
| <input type="checkbox"/> Actinic Keratoses (Pre Cancers) | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Basal Cell/ Squamous cell Skin Cancer | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Eczema/ Psoriasis | <input type="checkbox"/> Other _____ |

Do you wear Sunscreen?

Yes No If yes, what SPF? _____

Do you tan in a tanning salon?

Yes No

Family History

Do you have a family history of **Melanoma**?

Yes No

If yes, which relative? _____

Intake Form Page 2

Social History Details

Do you currently smoke cigarettes? Yes No

Have you ever smoked cigarettes? Yes No

Alcohol: none

Alcohol: less than 1 drink per day

Alcohol: 1-2 drinks per day

Alcohol: 3 or more drinks per day

Do you currently have any of the following?

Allergy to Epinephrine

Allergy to adhesive

Allergy to lidocaine

Allergy to latex

Allergy to topical antibiotic ointments

Artificial heart valve

Artificial joints within past two years

Blood thinners

Defibrillator

Pacemaker

Premedication prior to procedures

Rapid heartbeat with epinephrine

Pregnancy or planning a pregnancy

Occupation/Hobbies: _____

Jeffrey R. Hunek, M.D., P.A.
 Dermatology and Dermatologic Surgery
 Board Certified Diplomate,
 American Board of Dermatology

897 East Venice Ave Suite A Venice FL, 34285
 Tel: (941) 486-1404

Registration Form

Today's date:		Primary Care Physician:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		Gender:	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		Marital status (circle one)	
		Single / Married / Divorced / Separated / Widowed	
Birth date:	Social Security #:	Home phone:	Cell phone:
/ /		() -	() -
Florida Address:		City:	ZIP Code:
		State:	
Northern Address:		City:	ZIP Code:
		State:	
Email address:		Race:	Preferred Language:
			<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other
Preferred Pharmacy:		Ethnic Group:	
		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
		<input type="checkbox"/> Decline to Specify <input type="checkbox"/> Unknown	
Who were you referred to us by (please check one box):			
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____			
<input type="checkbox"/> Dr. _____ <input type="checkbox"/> Internet <input type="checkbox"/> Hospital			
INSURANCE INFORMATION			
(Please give your insurance card(s) to the receptionist)			
Person responsible for bill, if minor:	Birth date:	Address (if different):	Home phone:
	/ /		() -
Employer:	Employer address:		Employer phone:
			() -
Please indicate primary insurance: <input type="checkbox"/> Medicare <input checked="" type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross <input type="checkbox"/> Tricare <input type="checkbox"/> Cigna <input type="checkbox"/> Champus/Champva			
<input type="checkbox"/> Golden Rule <input type="checkbox"/> Humana <input type="checkbox"/> Oxford <input type="checkbox"/> United HealthCare <input type="checkbox"/> No Insurance (self-pay) <input type="checkbox"/> Other _____			
Subscriber's name:	Birth date:	Subscriber's S.S. #:	Policy #:
	/ /		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

IN CASE OF EMERGENCY

Name of local friend/ relative (not living at same address):	Relationship:	Primary phone: () -	Secondary phone: () -
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I Understand fees for professional and clinical services are payable at the time of service unless prior arrangements have been made. If any insurance claim is filed on my behalf, **I understand that my health insurance is a contract between myself and my insurance company; therefore, I am responsible for any deductible, co-payment, and balances for allowable services.** In the case where Dr. Hunek does not accept assignment nor participate with my insurance company, I am responsible ultimately for the entire balance. I authorize the release of medical or other information that may be necessary to request claim reimbursement from my insurance carrier(s) and request payment of benefits either to myself or to the party who accepts assignment. I request that payment of authorized Medicare benefits be made to **Jeffrey R. Hunek, M.D., P.A.** on my behalf for any services furnished to me at this office or billed through this office. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and the Social Security Administration, or their agents, intermediaries, or carriers, any information needed to determine these benefits for related services. I permit a copy of this authorization to be used in place of the original.

For MEDIGAP authorization I further request that payment of authorized MEDIGAP benefits be made on my behalf to **Jeffrey R. Hunek, M.D., P.A.** I authorize any holder of medical information about me to release to my MEDIGAP insurance needed to determine these benefits or the benefits payable for related services. If no insurance coverage is available, I agree to be fully responsible for all amounts billed.

FURTHER: I hereby authorize the release of my medical records and information to myself, my regular physician, whom I've named above and/or the referring physician who advised and scheduled my visit with Dr. Hunek and/or to any physician(s) to whom I've been referred by Dr. Hunek.

Patient/ Guardian signature

Date

Jeffrey R. Hunek, M.D., P.A.
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dr. Jeffrey R. Hunek, M.D., P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Jeffrey R. Hunek, M.D., P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jeffrey R. Hunek, M.D., P.A. reserved the right to revise it's Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Jeffrey R. Hunek, M.D., P.A.'s Privacy Officer at 897 E Venice Ave Suite A Venice, FL 34285

With this consent, Jeffrey R. Hunek, M.D., P.A. may discuss treatment, payment or healthcare operations with the following person(s):

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBERS AND RELATION TO YOU:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

By signing this form, I am consenting to Jeffrey R. Hunek, M.D., P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except the extent the practice has already made disclosures in reliance upon my prior consent, if I do not sign this consent, or later revoke it, Jeffrey R. Hunek, M.D., P.A. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date:

Print Name of Patient or Legal Guardian

DERMATOLOGY

FINANCIAL AND INSURANCE AUTHORIZATION

Thank you for choosing Jeffrey R. Hunek M.D., P.A. as your healthcare provider. We are committed to providing the best dermatological care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our policy. We ask you to read, sign and return this agreement prior to your treatment.

1. All patients should provide accurate and complete personal and insurance information prior to being seen.
2. All applicable co-pays, coinsurance, deductibles and personal balances both current and past due, are expected at the time of service. It is your responsibility to inform us of all limitations set forth by your insurance plan.
3. I authorize my insurance company payment be made to me and/or the Physician for services rendered.
4. We are not participating providers with the *MEDICAID* program. You will be responsible for payment at the time of service if you have Medicaid.
5. If your insurance does not respond within 90 days, you will be responsible for the balance in full.
6. We accept cash, check, Master Card, or Visa.

Returned Checks:

If a check is returned to us unpaid by your bank, you will be charged a fee of \$25.00.

I have read the Financial & Insurance Authorization. I understand and agree to all policies stated above.

Print Name

Signature

Date

**Receipt of Notice of Privacy Practices
Written Acknowledgment Form**

I, _____, have been provided with a copy of Jeffrey R. Hunek, M.D., P.A.'s Notice of Privacy Practices that describes how Jeffrey R. Hunek, M.D., P.A.'s office may use and disclose my health information and also describes my rights regarding my health information.

Signature of Patient

Date