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

- ☐ 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 or Past
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____

Have you had any surgeries on the following?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Biopsy/ Lumpectomy/ Mastectomy
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon: Inflam. 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_____

Have you had 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 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:_____

Monica L. Walker, 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

(Please Print)

Today's date:			Primary Care Physician:	
PATIENT INFORMATION				
Patient's last name: First: Middle:			Gender: ❑ Male ❑ Female	Marital status (circle one) Single / Married / Divorced / Separated / Widowed
Birth date: / /	Social Security #:	Home phone: ( ) -		Cell phone: ( ) -
Florida Address:			City: State:	ZIP Code:
Northern Address:			City: State:	ZIP Code:
Email address:			**Race:**	**Preferred Language:** ❑ English ❑ Spanish ❑ Other
Preferred Pharmacy:			**Ethnic Group:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to Specify ❑ Unknown	
Who were you referred to us by (please check one box): ❑ Dr. _____ ❑ Internet ❑ Hospital ❑ Family ❑ Friend ❑ Insurance Plan ❑ Yellow Pages ❑ Other _____				

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: ❑ Medicare ❑ Aetna ❑ Blue Cross ❑ Tricare ❑ Cigna ❑ Champus/Champva ❑ Golden Rule ❑ Humana ❑ Oxford ❑ United HealthCare ❑ No Insurance (self-pay) ❑ Other_____				
Subscriber's name:	Birth date: / /	Subscriber's S.S. #:	Policy #:	Group #:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Name of secondary insurance (if applicable):	Subscriber's name:		Policy #:	Group #:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				

IN CASE OF EMERGENCY			
Name of local friend/ relative (not living at same address):	Relationship:	Primary phone: ( ) -	Secondary phone: ( ) -

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. Walker 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 ***Monica L. Walker, 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 ***Monica L. Walker, 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. Walker and/or to any physician(s) to whom I've been referred by Dr. Walker.

_____ _____

Patient/ Guardian signature Date

Monica L. Walker, M.D., P.A.
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dr. Monica L. Walker, M.D., P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Monica L. Walker, 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. Monica L. Walker, 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 Monica L. Walker, M.D., P.A.'s Privacy Officer at 897 E Venice Ave Suite A Venice, FL 34285

With this consent, Monica L. Walker, 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 Monica L. Walker, 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, Monica L. Walker, 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 Monica L. Walker 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 Monica Walker, M.D., P.A.'s Notice of Privacy Practices that describes how Monica Walker, 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**