SOUTH ♦ TAMPA

DERMATOLOGY

Linda Flynn, M.D.
Abigail Ray, ARNP-BC

(Please Print)

General:
First Name_____
Last Name _____
Middle Name _____
Sex: M F Birth Date _____
Social Security Number _____
Race: Caucasian/African American/Hispanic/Asian
Employer _____
Occupation _____

Address:
Street_____
City _____
State _____
Zip Code _____

Contact:
Home Phone _____
Work Phone _____
Cell Phone _____
E-mail address _____

Emergency Contact:
First Name _____
Last Name _____
Relation to Patient _____
Home Phone _____
Work Phone _____
Cell Phone _____
Street _____
City _____
State/Zip Code _____

External Physicians
Referring Physician _____
Primary Care Physician _____

Street _____
Street _____

Preferred pharmacy:_____
Street_____
City _____
Phone Number _____
Fax Number _____

My medical information may be released to: _____
_____
_____
_____

Insurance:
I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.
Plan Name_____ Signature of Patient/Guarantor _____
Policy Holder: Patient/Guarantor (circle one)
In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, **payment is required for services at the time they are rendered.** We only file insurance for plans with which we have an agreement. You are responsible for any deductible, co-payment, coinsurance amount, charges rejected by your insurance company, or any cosmetic procedures. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/Guarantor _____ **Date:** _____

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Name: _____

Reason for Today's Visit:

Are you allergic to any medications? Yes No

If yes, please list with corresponding reaction:

Drug:	Reaction:
_____	_____
_____	_____
_____	_____

Please list all your current medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please circle if you have a history of any of the following conditions:

Heart valve replacement
Endocarditis
Congenital Heart Disease
Diabetes
Liver disease
Blood disorders (Anemia, HIV, Hepatitis)
Skin cancer: Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma

Circle any cosmetic procedures you would like any additional information on:
Obagi, Fillers (Juvederm, Sculptra, Radiesse), **Botox, Peels**
Laser for Brown Spots, Leg Veins, Facial Veins, Wrinkles, Scars

Include your email if you would like information regarding monthly specials?

_____

South Tampa Dermatology

Acknowledgement of receipt of Notice of Privacy Practices:
Please sign your name and print your name and date on this acknowledgement form. Then detach the form from the Notice and return your signed acknowledgment to the receptionist.

Signature:_____

Printed name:_____

Date:_____