SOUTH ◆ TAMPA
DERMATOLOGY

Linda Flynn, M.D. / Dana Hess, PA-C / Megan Thomas, PA-C/ Jessica Hage, PA-C

(Please Print Patient's Name)

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:** _____

** If you would like to provide your email address for future specials that our office runs please write your email here: _____

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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 (Voluma, Juvederm, Vollure, Vobella), **Botox, Peels**
Laser for Brown Spots, Leg Veins, Facial Veins, Wrinkles, Scars

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Acknowledgement of receipt of Notice of Privacy Practices:

Please sign your name and print your name and date on this Acknowledgement form. Then return your completed paperwork including your signed Acknowledgement to the receptionist.

Signature:_____

Printed name: _____

Date: _____