Florida Medical Clinic Dermatology
Your life. Our specialty.

Lowella Esperanza, MD
Florence Nappi, MD
Diana Jennings, APRN

Patient Name:_______________________________________ D.O.B.__________________ Sex: M ☐ F ☐
Reason for today's visit:____
Allergies to medications:____
Referred by:_________________________ PCP:___________________ Email_______________________

Current medication and dosages:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

***Do you take the following:**
Aspirin
Plavix
Pradaxa
Eliquis
Coumadin
Xarelto
Brilinta

***Do you have any allergies to the following:**
Latex
Tape
Ointment
Penicillin

Skin History:

Basal Cell Carcinoma Location: ______________________________
Squamous Cell Carcinoma Location: ______________________________
Dysplastic Nevus Location: ______________________________
Melanoma Location:______________________________
Merkel Cell Carcinoma Location:______________________________
Skin Lymphoma Location:______________________________

Eczema Granuloma Annulare Hidradenitis Suppurativa Psoriasis Seborrheic Dermatitis
Folliculitis Herpes Simplex Lichen Simplex Chronic Rosacea Vitiligo Keloids

How would you describe your PRESENT sun exposure? Heavy Moderate Light
How would you describe your PAST sun exposure? Heavy Moderate Light
With sun exposure, do you Burn Easily Bum Sometimes, Tan Easily Tan Easily, Never Burn
What sun protection do you use? Sunscreen – SPF?______ Hat Protective Clothing None
How many hours of sun exposure do you get on a daily basis?_________

Past Medical History:

Artificial Joint Replacements	Gout	Multiple Sclerosis
ADHD	Heart Attacks	Myasthenia Gravis
Allergic Rhinitis	Heart Devices (Pacemaker/defibrillator)	Neurologic Disorders
AIDS/HIV	Heart Valve Disease/Replacements	Organ Transplant
Arthritis	Hepatitis	Osteoarthritis
Asthma	Herpes Simplex (Genitals)	Osteopenia/Osteoporosis
Atrial Fibrillation	Hyperlipidemia	Peripheral Vascular Disease
Anxiety	Hypertension	Renal (Kidney) Disease
Bipolar Disorder	Hypothyroidism	Rheumatic Fever
Bleeding Disorders	Immunosuppressed	Seizure Disorders
Coronary Artery Disease / Stents	Irregular Menstrual Cycles	Sleep Apnea (Obstructive)
Cancer	Inflammatory Bowel Disease	Stroke
Congestive Heart Failure	Kidney Stones	Thyroid Disorders
COPD	Liver Disease	Tuberculosis
Diabetes	Lupus	Venous Insufficiency
Depression	Menopause	Vision Problems
Diverticulosis	Migraine Headaches	Other
Fibromyalgia	Mouth Sores	

Past Surgical History:

Appendectomy	Colon Surgery	Laminectomy
Adenoidectomy	Cosmetic Surgery	Prostate Surgery
Artificial Heart Valves	Gastric Bypass	Pacemaker Placement
Bladder Surgery	Hernia Surgery	Shoulder Surgery
Breast Surgery (for biopsy)	Hemorrhoidectomy	Tonsillectomy
Breast Surgery (for mastectomy)	Hernia Repair	Tubal Ligation
Coronary Artery Bypass Surgery	Hip Replacement	Vasectomy
Carpal Tunnel Surgery	Hysterectomy (Complete)	Other_______________
Cath Stent Placement	Hysterectomy (Partial)	____________________
Cesarean Section	Joint Replacement	____________________
Cholecystectomy	Knee Replacement	

Social History:

Marital History: Single Married Divorced Separated Widowed

Do you currently smoke? Yes No Former Smoker

Do you drink alcohol? Yes No If yes, how much per day?___________________

Do you partake in outdoor activities? (golf, tennis) Yes No

If yes, which ones? ____

Current or past occupation? ____

Family History:	Mother	Father	Brother	Sister	Other
Atherosclerosis					
Arthritis					
Asthma					
Coronary artery disease					
Cancer (please specify type)					
Cataract					
Color Blind					
Depression					
Diabetes					
Eczema					
Epilepsy					
Glaucoma					
Ischemic Heart Disease					
Hypertension					
Hyperlipidemia					
Macular Degeneration					
Mental Illness					
Migraine Headaches					
Osteoporosis					
Renal Disease					
Retinal Detachment					
Stroke					
Thyroid Disease					
Seasonal Allergies					
Other________________					

______________________________ ______________________________ __________

PATIENT/GUARDIAN SIGNATURE **SIGNED/REVIEWED BY PHYSICIAN/A.P.R.N.** **DATE**

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OFFICE POLICY

1. We see patients age six months and older. Minors (any person under the age of 18) must be accompanied by a parent or legal guardian on every visit.

2. **Please assist us by arriving on time so that we may accommodate everyone in a timely manner. If you arrive later than your scheduled appointment time we may need to reschedule, although we will make every attempt to ensure that you are seen in a timely manner. Please note the following: If you fail to show for your appointment or fail to cancel your appointment at least 24 hours in advance you will be charged a $50.00 fee. This fee must be paid prior to scheduling your next appointment.**

3. Our goal is to stay on time; however, many factors play a role in interfering with the schedule. Please assist us in our efforts to stay on schedule by limiting the number of problems you would like to address to one or two per visit. For example, a complete skin exam to check abnormal moles or skin cancer should be the only problem addressed during a visit. Attempting to address multiple problems often leads to inadequate counseling, time delays and eventually patient dissatisfaction. Please remember that skin problems are often complex and require adequate time for accurate diagnosis and treatment.

4. We offer cosmetic services such as Botox, Juvéderm, and laser treatments. During routine dermatology visits, it is difficult to provide an adequate education on these important topics without interference with the schedule. For your convenience, we provide complimentary consultations on our cosmetic services. Please contact our office to make an appointment with a cosmetic consultant.

5. **Insurance companies do not pay for cosmetic services.** They will not cover the removal of benign lesions (skin tags, moles, and warty growths) even if clothing or friction irritates the lesions. If coverage is in question, you may be asked to sign a waiver indicating your financial responsibility in the event of non-payment by your insurance company.

6. For existing patients, you may leave a message with the nursing staff for medical questions, prescription refills and laboratory results. Since we are very busy seeing patients during clinic hours we may not be able to respond to your request until after business hours. We will make every effort to accommodate you. We appreciate your patience.

7. Patients are responsible for their co-payment and/or deductible at the time services are rendered. Payments may be made by cash, check, or credit card. We do not accept temporary checks. ALL RETURNED CHECKS ARE SUBJECT TO A $25 CHARGE.

8. If a biopsy or surgery is performed, tissue is sent to a separate laboratory facility for processing and examination. These facilities will charge you or your insurance company for their lab services. These charges are distinct and separate charges from our dermatology office.

9. We make every effort to obtain payment from your insurance company. If you have questions about your bill, please feel free to contact our billing department at (813) 528-4975. Unpaid balances that are over 60 days overdue are subject to referral to a collection agency. Please be aware that once your account has been turned over to collections, you will incur a 30% surcharge on your existing balance.

____________________	____________________
PRINT NAME	**PATIENT SIGNATURE**
____________________	____________________
WITNESS	**DATE**

Florida Medical Clinic, LLC
Authorization to Verbally Share Protected Health Information

Patient Name:	Second Form of Identification (DOB/Account#)

I authorize FLORIDA MEDICAL CLINIC, LLC to verbally share protected health information with the following persons:

Last Name	First Name	Relationship	Phone#
1.			
2.			
3.			

This includes (please check all areas that apply)

All Medical Information
Lab Results
X-ray Results
Medication (Rx Renewal and Pickup)
Telephone Consults
Hospital Information
Insurance Information
Dialysis Clinic Information
Appointment Information
Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature____Date_______________

FMC Personnel____Date_______________