



DERMATOLOGY & CUTANEOUS SURGERY

We are an academic institution – What does that mean?

USF Health is an academic institution where future healthcare providers are trained. Below is a description of the different types of providers you may see during your visit.

- **Attending Physician:** This practitioner has completed medical school, a residency program, and is fully licensed and board certified. The attending physician is directly responsible for your medical and surgical care and will answer questions about your diagnosis and treatment plan. For more information on our providers please visit our website www.usfdermatology.com.
- **Nurse Practitioner (NP), Physician Assistant (PA):** These physician extenders are fully licensed, advanced practice healthcare professionals trained to care for you in our clinic setting.
- **Resident:** This is a licensed medical doctor that is in training to specialize his/her career in dermatology and cutaneous surgery.
- **Fellow:** This licensed medical doctor has already completed their residency in dermatology and is now concentrating on his/her sub-specialty (e.g. Mohs Surgery, Dermatopathology).
- **Medical Student:** This student is learning how to care for patients under the direct supervision of our physicians.



DERMATOLOGY & CUTANEOUS SURGERY

NEW PATIENT CHECKLIST

- Current Insurance Card
Physician referral (if required by your insurance)
Completed new patient questionnaire and health history
Medication list (see below) OR the actual medication bottles of all medications, vitamins and supplements
List of all brands and types of shampoo, cosmetics, and topical ointments and creams you are using daily or otherwise (see below)
Copies of your medical records received by our team prior to your visit.
Co-payment that is due at time of visit
A List of 3 questions for the provider relating to your concerns

Medication and Products/Cosmetics List

Your Preferred Pharmacy: Phone () FAX:
Address: Cross street:

Table with 4 columns: MEDICATION/PRODUCT, DOSE or BRAND, FREQUENCY, NOTES. Multiple empty rows for data entry.



DERMATOLOGY & CUTANEOUS SURGERY NEW PATIENT FORM

PATIENT NAME:

DOB:

ADDRESS:

PHONE#: _____

DID A DR. SEND YOU TO US FOR A CONSULTATION? Yes No IF YES, please fill out this section:

PRIMARY CARE DR:

DR'S TELEPHONE #: _____

DR'S ADDRESS:

DR'S FAX #: _____

SEND PRESCRIPTIONS ELECTRONICALLY TO PHARMACY? Yes No

PHARMACY NAME: _____

PHARMACY PHONE #: _____

PHARMACY CROSS STREET: _____

CURRENT MEDICATIONS (INCLUDE HERBS/VITAMINS):

Table with 3 columns: Allergy Type, Yes, No. Rows include Latex, Tape, Ointment, Penicillin.

MEDICATION ALLERGIES (INCLUDE TOPICALS): _____

REASON FOR VISIT (Please mark on diagram on back also):

LOCATION OF PROBLEM: _____

DURATION OF PROBLEM: _____

TRIGGERS OF PROBLEM: _____

PREVIOUS TREATMENTS: _____

Table with 3 columns: Use/Status, Yes, No. Rows include Sunscreen, Pregnant/Breast Feeding.

DO YOU HAVE NOW OR HAVE YOU HAD A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

Table with 3 columns: Condition, Yes, No. Categories include Cardiovascular, Respiratory, Endocrine, Psychiatric.

Table with 3 columns: Condition, Yes, No. Categories include Gastroenterology, Genitourinary, Allergic, Neurologic, Skin.

Table with 3 columns: Condition, Yes, No. Categories include Musculoskeletal, Eyes, Head/Ears/Nose/Mouth, Hematologic.

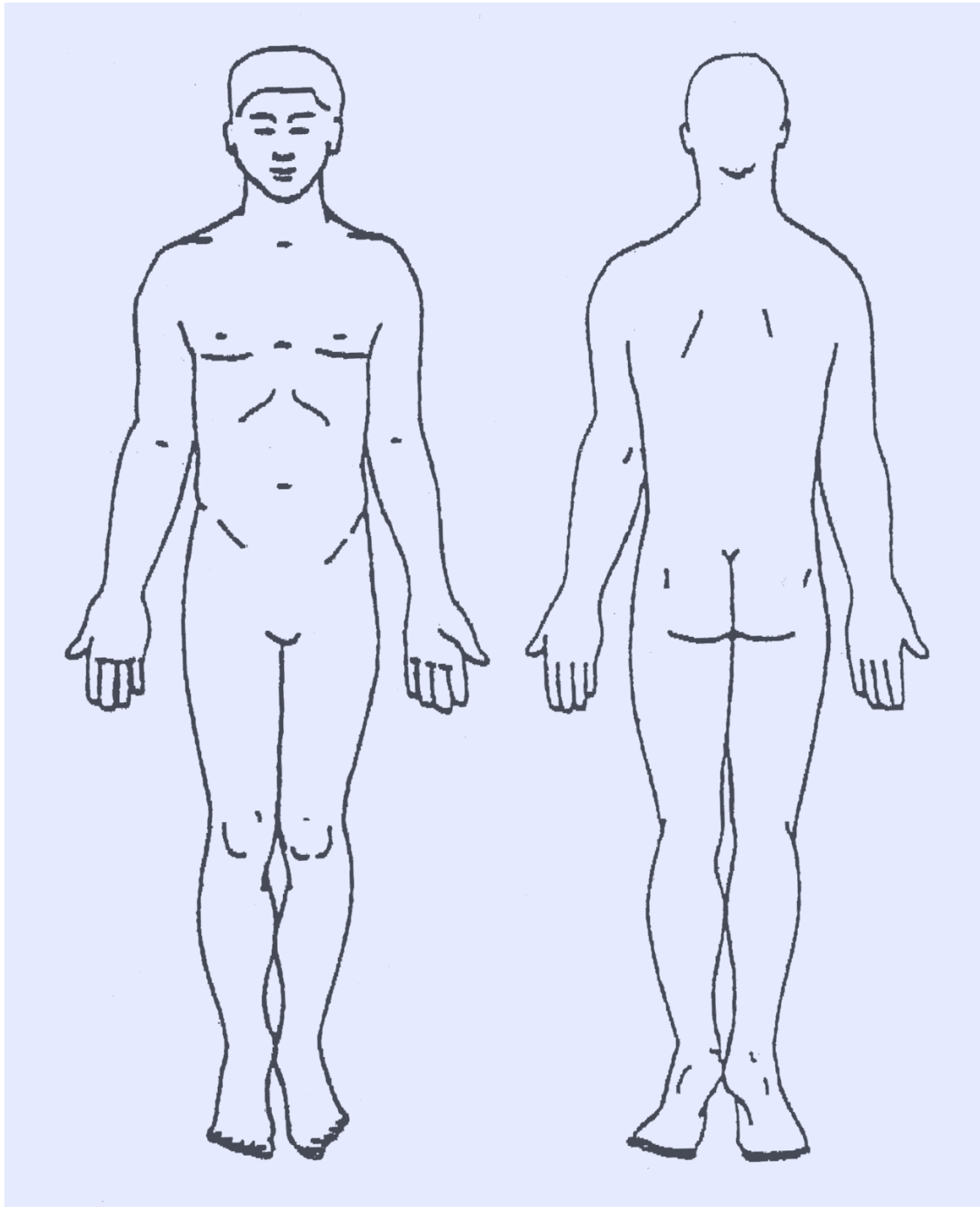
Table with 3 columns: Use, Yes, No. Categories include DO YOU CURRENTLY USE: Aspirin, Vitamin E, Retinoids, etc.

Table with 3 columns: Family History, Yes, No. Category: ANYBODY IN YOUR FAMILY WITH: Melanoma, Asthma, etc.

PATIENT SIGNATURE: _____

REVIEWED BY: _____

PLEASE MARK THE AREAS RELATING TO YOUR SKIN PROBLEM BELOW:



Authorization to Records Custodian
for the Release of Medical Records



13330 USF Laurel Drive, MDC 33
Tampa, FL 33612
Phone (813) 974-9818
Fax (813) 974-4280

Patient's Name _____ Date of birth _____
Patient's last 4 Number of Social Security No. _____ Medical Record No. _____
Representative Name _____ Relationship to Patient _____
Representative Address _____ Legal Authority _____
Verification of Identity _____ Verification of Authority _____

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)

Release to: _____ Obtain from: _____
Name _____ Name _____
Street Address _____ Street Address _____
City, State, Zip Code _____ City, State, Zip Code _____

Purpose of requesting records: _____

I specifically authorize the use and disclosure of the following PHI: (Please provide a detailed description of the particular data and period of time you are requesting) **Initial next to A, B, or C and circle specifics**

- A. _____ ALL medical records in the custody of USF Health _____
_____ Records of the treating physician _____
_____ Last office visit Note, or Medication list _____
_____ Labs or Pathology _____
_____ Radiology report or Images _____
- B. _____ Other Information Requested _____
- C. _____ **I further authorize the release of records regarding**
 - A. _____ Mental/Emotional Health
 - B. _____ Substance Abuse
 - C. _____ HIV/AIDS
 - D. _____ Genetic Information
 - E. _____ Records created by non USF health providers

I understand that I may be charged for the copying of these patient records and payment is expected at the time the copies are received from USF Health.

If requesting information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; (3) mental or emotional health or psychiatric care, excluding psychotherapy notes or (4) genetic testing, specific authorization on this form or a court order is required since this information is privileged. A separate authorization is required for psychotherapy session notes. Psychotherapy session notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. 45 CFR 164.501.

I may revoke this authorization form at any time by notifying the above-referenced records custodian at the location listed above, of my intent to revoke this authorization. Returning [a copy] of this form, signed and dated with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by the University of South Florida prior to the University receiving my written notice of revocation. This authorization form expires one year from signature or on _____ or on the occurrence of _____. I understand that protected health information released to a third party pursuant to this form may be re-disclosed and may no longer be protected by state and federal law.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.

I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from the University of South Florida.

I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form.

I understand that I may refuse to sign this form.

Signature of patient or personal representative

Date

Printed name of patient or personal representative
(circle one)

Relationship to patient giving representative authority to act for patient