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.

13330 USF Laurel Drive, 6th Floor
Tampa, FL 33612
Dermatology (813) 974-4744

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: _____

MEDICATION/PRODUCT	DOSE or BRAND	FREQUENCY	NOTES

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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):

DO YOU HAVE AN ALLERGY TO:		
Latex	Yes	No
Tape	Yes	No
Ointment	Yes	No
Penicillin	Yes	No

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: _____

DO YOU CURRENTLY USE:		
Sunscreen	Yes	No
ARE YOU PREGNANT OR BREAST FEEDING?		
	Yes	No

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

Cardiovascular:		
Heart murmur	**Yes**	**No**
Artificial Valves	**Yes**	**No**
Mitral valve prolapse	**Yes**	**No**
Pacemaker/Defibrillator/AICD	**Yes**	**No**
High blood pressure	**Yes**	**No**
Arrhythmia	**Yes**	**No**
Congestive Heart Failure	**Yes**	**No**
Angina /chest pains	**Yes**	**No**
Coronary Artery Disease/Stents	**Yes**	**No**
Low blood pressure	**Yes**	**No**
Heart Attacks	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**
Require Oxygen Tank	**Yes**	**No**
Respiratory:		
Shortness of Breath	**Yes**	**No**
Asthma	**Yes**	**No**
Emphysema /Bronchitis	**Yes**	**No**
Tuberculosis	**Yes**	**No**
Endocrine:		
Diabetes Mellitus	**Yes**	**No**
Thyroid Disease	**Yes**	**No**
Psychiatric:		
Panic Attacks	**Yes**	**No**
Depression	**Yes**	**No**
Bipolar Disorder	**Yes**	**No**

Gastroenterology:		
Ulcers	**Yes**	**No**
Difficulty Swallowing	**Yes**	**No**
Inflammatory Bowel	**Yes**	**No**
Behcet's Disease	**Yes**	**No**
Liver Disease	**Yes**	**No**
Genitourinary:		
Kidney Stones	**Yes**	**No**
Kidney Failure	**Yes**	**No**
Allergic:		
Hives	**Yes**	**No**
Hayfever	**Yes**	**No**
Eczema	**Yes**	**No**
Neurologic:		
Stroke	**Yes**	**No**
Seizures	**Yes**	**No**
Bell's Palsy	**Yes**	**No**
Skin:		
Pre-Cancers	**Yes**	**No**
Basal cell cancer	**Yes**	**No**
Squamous cell cancer	**Yes**	**No**
Melanoma	**Yes**	**No**
Atypical moles	**Yes**	**No**
Keloid/Thick Scars	**Yes**	**No**
MRSA Infections	**Yes**	**No**

Musculoskeletal:		
Arthritis	**Yes**	**No**
Muscle Weakness	**Yes**	**No**
Artificial Joints	**Yes**	**No**
If yes, what year?		
Eyes:		
Impaired Vision	**Yes**	**No**
Light Sensitivity	**Yes**	**No**
Vision Changes	**Yes**	**No**
Head/Ears/ Nose/ Mouth:		
Tinnitus	**Yes**	**No**
Vertigo	**Yes**	**No**
Mouth Sores	**Yes**	**No**
Nasal congestion	**Yes**	**No**
Headaches	**Yes**	**No**
Hematologic		
Blood borne pathogens	**Yes**	**No**
HIV/AIDS	**Yes**	**No**
Hepatitis	**Yes**	**No**
Blood Cancers (Leukemia)	**Yes**	**No**
Internal Cancers	**Yes**	**No**
Chemotherapy	**Yes**	**No**
Radiation Therapy	**Yes**	**No**
Bleeding/Clotting Disorders	**Yes**	**No**
Immunosuppressed	**Yes**	**No**
Organ Transplant	**Yes**	**No**

DO YOU CURRENTLY USE:						
Aspirin	**Yes**	**No**		Vitamin E	**Yes**	**No**
Plavix/Pradaxa/Xarelto/Aggrenox	**Yes**	**No**		Retinoids	**Yes**	**No**
Coumadin/Other Anti-Coagulants	**Yes**	**No**		Ginko Biloba/Herbs	**Yes**	**No**
Advil/Ibuprofen	**Yes**	**No**		Implantable Medical Devices	**Yes**	**No**
Tobacco	**Yes**	**No**		Alcohol	**Yes**	**No**

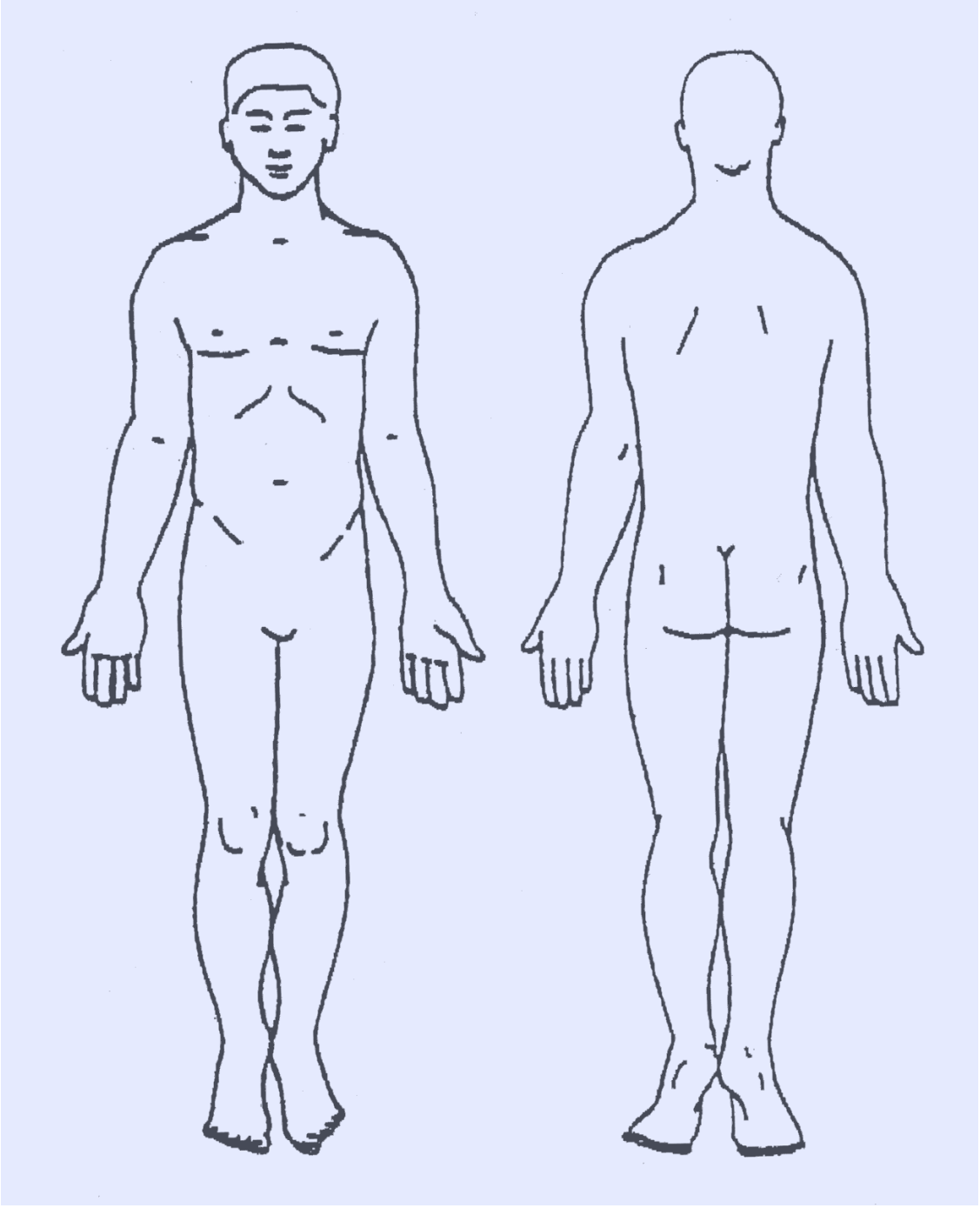
ANYBODY IN YOUR FAMILY WITH:		
Melanoma	**Yes**	**No**
Asthma	**Yes**	**No**
Eczema	**Yes**	**No**
Lupus	**Yes**	**No**
Autoimmune disorders	**Yes**	**No**

PATIENT SIGNATURE: _____ **REVIEWED BY:** _____

USF HEALTH

DERMATOLOGY & CUTANEOUS SURGERY NEW PATIENT FORM

PLEASE MARK THE AREAS RELATING TO YOUR SKIN PROBLEM BELOW:



Authorization to Records Custodian for the Release of Medical Records

USF HEALTH

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 _____ Verfication 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 occurence 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** Relationship to patient giving representative authority to act for patient
(circle one)