Florida Dermatologic Surgery & Aesthetics Institute, P.A.

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)

Board Certified Dermatopathologist

Fellowship Trained Mohs Surgeon (Mohs College)

ACMS American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

General Information Date:________________

Name:____________________________________ Age:_____ Date of Birth_______/_______/________

Last First Middle Initial

Sex: ⬜M ⬜F Primary Care Physician:____

Mailing Address:____

City State Zip Code

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

Do you have an alternate address? Yes No **if yes, please print below:**

____

Would you like to receive emails for notice of upcoming events? ☐ Yes ☐No

Email:________________________

Marital Status: (Circle One) Single Married Divorced Widowed Separated

Employment Status: (Circle One) Full-time Part-time Retired Other:_______________________

Spouse/Parent Name (If Applicable)**:** Last________________________ First________________________

Age:_____ DOB:_______/_______/________

RESPONSIBLE PARTY (If different from patient)

Name of Insured: Last________________________ First________________________

DOB (Of insured):_______/_______/________

Mailing Address:____

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

Relationship to Patient: _______________________

Ashraf M. Hassanein, M.D., Ph.D., FACMS
Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

INSURANCE INFORMATION (Please present insurance card at the time of check-in).

Primary Insurance Name:____

Policy Holder's Name: Last_____________________ First_____________________

SS#______-______-______ Date of Birth_______/_______/________

Group #: _____________________ Contract #: _____________________________

****Secondary Insurance Information** (If applicable)**:**

Secondary Insurance Name:____

Policy Holder's Name: Last_____________________ First_____________________

SS#______-______-______ Date of Birth_______/_______/________

Group #: _____________________ Contract #: _____________________________

In case of an emergency, who should we notify (other than those already listed above)?

Name:________________________________ Primary Number: (_____) ______ - ______

Name:________________________________ Primary Number: (_____) ______ - ______

How were you referred to this office? Advertisement Family Friend Other:_____________

Referring Physician:__________________________________ **Phone:** (_____) ______ - ______

All of the above is correct to the best of my knowledge, and I agree to notify this office of any changes in a timely manner.

Patient or Responsible Party Signature:___________________________Date:______________

ACMS American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

<u>Financial Responsibility Agreement</u>

I have been informed and understand that I am financially responsible for payment of services at the time of the visit. I also understand that all laboratory charges are billed separately from the physician and are my responsibility to pay. In the event that my doctor deems any procedure medically necessary for my treatments, but the cost is not covered by my health insurance, I agree to assume full financial responsibility for payment.

Signed:____ Date:_______________

<u>Assignment of Benefits</u>

I, the undersigned, hereby authorize the above named medical group to release to my insurance company any medical information acquired to assist in processing any health insurance and/or medical claims for services received from my doctor. I authorize payment of such claims to be permanently assigned to Florida Dermatologic Surgery & Aesthetics Institute. I also understand that I am financially responsible for all changes whether or not paid by the said insurance company.

Signed:____ Date:_______________

<u>Informed Consent</u>

I understand that during my course of treatments, unforeseen conditions may occur that necessitates a skin biopsy(s) to be taken by shave, punch, and/or excision. In addition, I also give permission to have minor surgical procedures and any subsequent treatment as deemed necessary as long as the risk and complications are discussed with me prior to the said procedure. These risks include, but are not limited to, scarring, bleeding, swelling, pain, deformity, infection, and/or ulceration. I will also inform the dermatologic practitioner of any possible contraindications to the planned procedure, including medications, such as anticoagulants, aspirin, cardiac, infectious, or psychotropics.

Signed:____ Date:_______________

Dana Center – 11950 CR 101, Suite 203 • The Villages, FL 32162 • Telephone (352) 430-2580 • Fax (352) 430-2651
3145 Citrus Tower Blvd, Bldg 14, Suite A • Clermont, FL 34711 • Telephone (352) 241-6111 • Fax (352) 430-2651
7343 Powell Rd • Wildwood, FL 34785 • Telephone (352) 913-3376 • Fax (352) 913-3375

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

PATIENT COMMUNICATION FORM

Family and friends, it is the office policy to not release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "No" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing, or call our staff).

Spouse:____ Yes____ No____

Other:____ Yes____ No____

Other:____ Yes____ No____

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy to not release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(PLEASE CONTINUE TO THE NEXT PAGE).

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)

Board Certified Dermatopathologist

Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C

Shelly Hansel, PA-C

Maria Lipari, PA-C

Board Certified Physicians Associates

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "No" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff to assist you).

Spouse:____ Yes_____ No_____

Other:____ Yes_____ No_____

Other:____ Yes_____ No_____

PATIENT MUST COMPLETE

A. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I allow the following forms of communication: (Check the following that apply).

☐ Telephone:___________________ Detailed message____ Call back number ONLY____

___________________ Detailed message____ Call back number ONLY____

☐ Written correspondence: Mailed to home address____ Email____

PRINTED NAME:____

PATIENT/Parent/Guardian Signature:____

(PLEASE CONTINUE TO THE NEXT PAGE).

Ashraf M. Hassanein, M.D., Ph.D., FACMS
Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

Medical History

Patient Name (please print):________________________________Age:____Date of Birth:____/____/____

Date forms were completed:______/______/______ Reason for visit:________________________________

Height:____'____" Weight:________lbs. Eye Color:__________ Hair Color:__________

Past Medical History: (please check all that apply)

☐ Depression	☐ ADD/ADHD	☐ Anxiety	☐ Seasonal Allergies
☐ Thyroid Abnormalities	☐ High Blood Pressure	☐ Lung Disease	☐ Liver Disease/Hepatitis
☐ Developmental Abnormalities	☐ Kidney Disease	☐ HIV/AIDS	☐ Diabetes
☐ Cancer **(detail below)**	☐ Arthritis	☐ Heart Disease	☐ Headaches
☐ Stroke	☐ Seizures	☐ Angina	☐ Heart Attack
☐ Mitral Valve Prolapse	☐ Heart Valve	☐ Bypass	☐ Stents
☐ COPD	☐ Emphysema	☐ Bronchitis	☐ Asthma
☐ TB	☐ Prostate	☐ Anemia	☐ Bleed or Bruise Easily
☐ Communicable Diseases	☐ GI Issues	☐ Paralysis	☐ Hip/Knee Replacement
☐ Congestive Heart Failure	☐ Pacemaker		

Other Medical Conditions:

____

____

Comments:

____

(PLEASE CONTINUE TO THE NEXT PAGE).

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

Please list any past surgeries/accidents/illnesses (please include approximate dates):

____

____

____

Past Skin History: (please check all that apply)

☐ Acne	☐ Actinic Keratosis	☐ Atypical/Dysplastic Moles
☐ Basal Cell Carcinoma	☐ Squamous Cell Carcinoma	☐ Melanoma
☐ Eczema/Atopic Dermatitis	☐ Psoriasis	☐ Other Skin Cancer:____________
☐ Rosacea	☐ Allergic Contact Dermatitis	☐ Hair Loss
☐ Warts	☐ Molluscum	☐ Shingles
☐ Fever Sores	☐ Rashes	☐ Other: (please detail below)

____

____

Comments: ____

____

Sunscreen Use: ☐ Daily ☐ Sometimes if Sunny ☐ Always if Sunny ☐ Rarely/Never

Current Sun Exposure: ☐ Very Little ☐ Moderate ☐ A Lot

Past Sun Exposure: ☐ Very Little ☐ Moderate ☐ A Lot

(PLEASE CONTINUE TO THE NEXT PAGE).

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

Do you have a current skin care regimen?	☐ **No**	☐ **Yes (if "yes" please explain below)**

____

____

____

Females: (please check all that apply)

☐ Pregnant	☐ Nursing	☐ Planning children in the next 6 months
☐ Tubal Ligation Hysterectomy	☐ Uterine Ablation	☐ Method(s) of birth control: **(please list below)**

____

____

Please list all medications (including topical, over-the-counter, and supplements):

____

____

____

____

Medication Allergies:

____

____

Other Allergies:

____

____

Dana Center – 11950 CR 101, Suite 203 • The Villages, FL 32162 • Telephone (352) 430-2580 • Fax (352) 430-2651
3145 Citrus Tower Blvd, Bldg 14, Suite A • Clermont, FL 34711 • Telephone (352) 241-6111 • Fax (352) 430-2651
7343 Powell Rd • Wildwood, FL 34785 • Telephone (352) 913-3376 • Fax (352) 913-3375

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

Family History (First Degree Relatives Only): (please check all that apply)

☐ Unknown	☐ Adopted	
☐ Depression	☐ Seasonal Allergies	☐ Diabetes
☐ Thyroid Disease	☐ Autoimmune Disease	☐ Lupus
☐ Acne	☐ Actinic Keratosis	☐ Atypical/Dysplastic Moles
☐ Basal Cell Carcinoma	☐ Squamous Cell Carcinoma	☐ Melanoma
☐ Eczema/Atopic Dermatitis	☐ Psoriasis	☐ Rosacea
☐ Allergic Contact Dermatitis	☐ Hair Loss	☐ Warts
☐ Molluscum	☐ Other Skin Cancer:____________________	
☐ Other not listed (detail):____________________		

Cancer:

Other Medical Conditions:

Comments:

Living Arrangement: (please check all that apply)

☐ Alone	☐ With Family	☐ Nursing Home:
☐ Other not listed (detail):____________________		

(PLEASE CONTINUE TO THE NEXT PAGE).

Ashraf M. Hassanein, M.D., Ph.D., FACMS

Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

Smoking: ☐ Never ☐ Occasionally/Socially ☐ Daily

Alcohol: ☐ Never ☐ Occasionally/Socially ☐ Daily

Recreational Drug Use: ☐ Never ☐ Occasionally/Socially ☐ Daily

(Please explain):____

Review of Symptoms:(please check any symptoms that you have experienced in the last month)

☐ Fatigue	☐ Chest Pain	☐ Swelling of Feet, Ankles, Hands
☐ Fever/Chills	☐ Headache	☐ Hormone Problem
☐ Frequent Diarrhea	☐ Nausea/Vomiting	☐ Excessive Thirst/Urination
☐ Blood in Urine	☐ Kidney Stones	☐ Slow to Heal
☐ Anemia	☐ Bruise/Bleed Easily	☐ Past Transfusion
☐ Joint Pain/Weakness	☐ Thinning Hair	☐ Sun Sensitivity
☐ Nail Changes	☐ Dry Skin	☐ Rash/Itching
☐ Memory Loss	☐ Cough	☐ Sleep Problems
☐ Asthma	☐ Shortness of Breath	☐ Suicidal Thoughts

(PLEASE CONTINUE TO THE NEXT PAGE).

Ashraf M. Hassanein, M.D., Ph.D., FACMS
Board Certified Dermatologist (ABPS)
Board Certified Dermatopathologist
Fellowship Trained Mohs Surgeon (Mohs College)

ACMS American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

Rosy Singleton, PA-C
Shelly Hansel, PA-C
Maria Lipari, PA-C
Board Certified Physicians Associates

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of **Florida Dermatologic Surgery & Aesthetics Institute, P.A.**, and I hereby acknowledge receipt of this facility's Notice of Privacy Practices.

Name (Please Print):____

Name (Please Sign):____

Date:_______/_______/_______

OR

I am a parent or legal guardian of (patient name):___________________________________.
I hereby acknowledge receipt of this facility's Notice of Privacy Practices with respect to the patient.

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other:______________________

Name (Please Print):____

Name (Please Sign):____

Date:_______/_______/_______

Thank you for choosing our practice and becoming part of the Floriderm family.
Your trust in our care means a great deal!

Dana Center – 11950 CR 101, Suite 203 • The Villages, FL 32162 • Telephone (352) 430-2580 • Fax (352) 430-2651
3145 Citrus Tower Blvd, Bldg 14, Suite A • Clermont, FL 34711 • Telephone (352) 241-6111 • Fax (352) 430-2651
7343 Powell Rd • Wildwood, FL 34785 • Telephone (352) 913-3376 • Fax (352) 913-3375