Lawrence A. Schiffman, D.O., FAOCD, P.L.
3650 N.W 82nd Avenue
Suite 306
Doral, FL 33166
P: 305.735.9474
www.miamiskindr.com

PATIENT INFORMATION:

Today's Date:

LAST NAME:_____ FIRST NAME:_____ M.I._____

Social Securtity: _____-_____-_____ Country of Origin: _____ Place of Residence: _____

Date of Birth: _____ /____ /_____ Age:_____ Sex: _____ Marital Status: _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip_____

Email:_____ Can we email/text you appointment reminders, promotions, etc? YES NO

Phone (Mobile): _____ Phone (Home): _____ Phone(Work): _____

Employer : _____ Occupation: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

PHARMACY INFO:

Name: _____ Phone: _____ Zip Code: _____

IF CHILD, PLEASE PROVIDE THE FOLLOWING:

Age of Child: _____

Name of Guardian/ Primary Insurance Holder: _____

Date of Birth of Guardian: _____/_____/_____

Relation to Patient: _____

PRIMARY CARE PHYSICIAN:

Name: _____ Phone: _____

How did you hear about us?

- ☐ Referral from Dr. _____
- ☐ Family or Friend
- ☐ Zocdoc
- ☐ Online: Google, Yahoo
- ☐ Advertisement

What is the reason for your visit today? _____

Do you currently have a non-healing sore/lesion? YES NO (please circle)

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PAST MEDICAL HISTORY: Please check the box for all that apply.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD/ Ulcer
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Hepatitis/Liver Disease
- ☐ Herpes
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Syphilis
- ☐ Tuberculosis
- ☐ Valve Replacement
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Autoimmune Disease
- ☐ Defibrillator
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Scleroderma
- ☐ **NONE**

☐ Other:

PAST SURGICAL HISTORY: Please check the box for all that apply.

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ MOHS Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilatera
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ **NONE**

☐ Other:

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LAST MENSTRUAL PERIOD:

What was the first day of your last menstrual period? _____
Are you currently **PREGNANT**: ……YES NO (Please circle)
Are you currently **Breast Feeding**:---------- YES NO (Please circle)

PAST DERMATOLOGICAL HISTORY: Please check the box for all that apply.

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Cold Sores
- ☐ Herpes
- ☐ Genital Warts
- ☐ Warts
- ☐ Molluscum
- ☐ Seborrhea/Dandruf
- ☐ Boils
- ☐ **NONE**

☐ Other:

Do you wear **Sunscreen**? YES NO (please circle)

If yes, what SPF? _____

Do you tan in a **tanning salon**? YES NO (please circle)

Do you have a <u>family history</u> of MELANOMA? YES NO (please circle)

If yes, which relative(s)? _____

Have you ever been diagnosed with or treated for Skin Cancer? YES NO (please circle)

If yes, which Type of Skin Cancer:_____

MEDICATIONS: Please list ALL current **Medications** and **Supplements** below.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please check the box below if you are you taking any of the following?

- ☐ Aspirin
- ☐ Blood Thinner
- ☐ Aspirin-like products
- ☐ Smoker
- ☐ Alcohol
- ☐ Recreational Drugs
- ☐ Birth Control Pills
- ☐ Birth Control Implant:

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ALLERGIES : Please list all allergies and associated reactions.

MEDICATION ALLERGY:_____

TOPICAL ALLERGY:_____

FOOD ALLERGY:_____

PLEASE **CHECK** THE BOX IF YOU HAVE ANY **ALLERGY** TO THE ANYTHING LISTED BELOW.

- ☐ **Neomycin**
- ☐ **Xylocaine**
- ☐ **Lidocaine**
- ☐ **Latex**
- ☐ **Epinephrine**

SOCIAL HISTORY: Please check the box for all that apply.

Smoking:
- ☐ Currently Smokes - daily
- ☐ Currently Smokes - not daily
- ☐ Smoked in the past
- ☐ Never smoked

Total years smoked _____

Total packs smoked per day _____

Date you quit smoking? ____/____/_____

Alcohol:
- ☐ Alcohol - none
- ☐ Alcohol - < 1 drink daily
- ☐ Alcohol - 1-2 drinks daily
- ☐ Alcohol - 3 + drinks daily

Sexual Activity:
- ☐ Not sexually active
- ☐ Sexualy active with one partner
- ☐ Sexually active with more than one partner
- ☐ Same sex partner

Drugs:
- ☐ Drug Use
- ☐ IV Drug Use

Exercise:
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times per week
- ☐ A few times per month
- ☐ Never
- ☐ Other _____

Do you feel safe at home? YES NO (please circle)

Driving Status: Check all that apply
- ☐ Drive in the Daytime
- ☐ Drive at Night

Race: _____

Ethnicity: _____

Primary Language: _____

Caffeine Use:
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times per week
- ☐ A few times per month
- ☐ Never
- ☐ Other _____

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REVIEW OF SYSTEMS: Are you currently experiencing any of the following? Please check YES or NO

Symptoms	YES	NO
History of Melanoma		
Pacemaker		
Defibrillator		
Artificial joints within past two years		
Artificial heart valve		
Premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Breastfeeding or lactation		
Allergy to lidocaine		

Symptoms	YES	NO
Fainting		
Immunosuppression		
Changing mole		
Rash		
Hay fever		
Wheezing		
Rapid heart beat with epinephrine		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Yeast infections with antibiotics		
GI upset with antibiotics		

Other than the services you are here for, which **additional** services would you like to learn about? (Check all that apply)

❑ Skin care advice	❑ Chemical peel	❑ Mole removal
❑ Skin care products	❑ Blotchy skin	❑ Neck wrinkles
❑ Facial injectables/fillers	❑ Facial veins	❑ Scar revision
❑ Facial fine lines/wrinkles	❑ Facial redness	❑ Stretch Marks Abdomen/ Hips Legs
❑ Thin lips	❑ Brown spots/age spots/freckles	❑ Facial or Body contouring
❑ Length of eyelashes	❑ Drooping brow	❑ Unwanted hair
❑ Fullness of eyelashes	❑ Drooping eyelids	❑ Cellulite
❑ Dark Circles	❑ Facial fullness/drooping	

Have you ever had the following treatments/procedures? (Please check all that apply)

☐ Botox, Dysport, or Xeomin	☐ Lifestyle Lift
☐ Filler (Restylane, Juvederm, Voluma, Radiesse, Perlane)	☐ Face Lift
☐ Laser Hair Removal	☐ Plastic Surgery
☐ Cellulite Treatment	☐ Tummy Tuck
☐ IPL/ Photofacial	☐ Eyelid Repair/ Blepharoplasty
☐ Sclerotherapy for leg veins	☐ Hair Transplant

Please answer the following questions by circling appropriate choice:

When looking at my face in the mirror, I believe_____my true age.

Younger Than True Age Older Than

When looking in the mirror, I am: _____with the appearance of my wrinkles.

Not Concerned Somewhat Concerned Very Concerned

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PHOTO CONSENT

I, the undersigned, do hereby agree to the following. I am allowing Dr.Schiffman, or a staff member, to take photos of my treatment and/ or treated areas to be used for the purpose of monitoring my progress.

At my request, my identity will remain anonymous._____ (please initial)

Print Name:_____

Signature:_____Date:_____

Witness:_____Date:_____

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as guardian, agent or as patient that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to pay the account, or "your part" of the charges of the physician at the time of services. We accept Visa, MasterCard and American Express for your convenience. Interest shall be charged beginning 45 days after date of service until paid, and will accrue at the rate of 12% per annum. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes payment of medical benefits to the Doctor when an assigned claim is filed.

_____ Print Patient Name

_____ Signature or Guardian

CANCELLATION POLICY

If you are unable to attend to your appointment, please notify our office 24 hours prior to your scheduled appointment. If the appointment has not been cancelled at least 24 hours prior to your scheduled appointment, then a $30.00 No-Show Fee will be charged to your account. Please sign indicating that you understand and are aware of this office policy.

_____ _____

Patient Signature Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____**(Initial)**With my consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L. Notice of Privacy Practices for a more complete description of such uses and disclosures.

_____ **(Initial)** I have the right to review the Notice of Privacy Practices prior to signing this consent. LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., Privacy Officer at 3650 NW 82ND AVENUE, DORAL, FL 33166.

_____**(Initial)**With my consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may call my home or other designated location and leave message on voice mail or in person in references to any items that assist the practice to carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

_____ **(Initial)** With my consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

_____ **(Initial)** With my consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statement. I have the right to request that LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., restricts how it uses or discusses my PHI to carry out TPO.

_____ **(Initial)** However, the practice is not required to agree to my requested, but if it does, it is bound by this assignment. By signing this form, I am consenting to LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L. use and disclosure of my PHI to carry out TPO.

_____ **(Initial)** I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L., may decline to provide treatment to me.

_____ **(Initial)** By my signature on this line, I authorize LAWRENCE A. SCHIFFMAN, D.O. FAOCD P.L. to contact me by phone (cell or home), email, or text by automated system to provide me with practice updates, specials on products and services and other information**.**

Also, with the HIPAA privacy rules we will require written permission to release/discuss any of your medical records with any family members and/or friends. If you are at least 18 years of age, please list anyone we can release information to.

_____	_____
Signature of Patient	Printed Name
_____	_____
Legal Guardian Signature	Legal Guardian Printed Name

Thank you for filling out these forms, as they will improve the quality of your care. We would like to welcome you to our office and hope your experience here is a pleasant one. We are a digital office, utilizing computers and iPads to document your visits with us. We are also a teaching office, training a new generation of dermatologists in 21st century skin care and medical technologies. Our medical team will do our very best to ensure you receive top-notch medical treatment. Thanks for choosing Dr. Schiffman as your dermatologist.