

JOHN P. KARTSONIS, M.D., P.A.
DERMATOLOGY & DERMATLOGIC SURGERY

Patient Information

Patient's Name _____ Marital Status _____ Guardian's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Billing Address (if different) _____

Date of Birth _____ Age _____ Sex _____ SS# _____

Home Phone () _____ Cell Phone () _____

Employer _____ Occupation _____ Work Ph. _____

REFERRED BY _____

Primary Insurance Information

Insurance Company Name _____

Policy # _____ Group # _____

Insured's Name _____ **Relationship to Patient** _____

Insured's Social Security # _____ **D.O.B.** _____

Secondary Insurance Information

Insurance Company Name _____

Policy # _____ Group # _____

Insured's Name _____ **Relationship to Patient** _____

Insured's Social Security # _____ **D.O.B.** _____

YOU ARE RESPONSIBLE to ensure that both your referral and insurance are valid for the date of your visit. As a courtesy, our office will file your insurance claim with the information you provide us one time per visit. If we receive a denial or no timely response, you will be responsible for payment. **Co-payments and payment for cosmetic procedures are collected on the date of service.** We accept cash, check, Visa or MasterCard. **The fee for a missed appointment without 24 hour notice is \$25.00 The fee for a missed surgery/procedure without 48 hour notice is ½ the fee or at least \$100.**

Signature _____ Date _____

Patient Name: _____ Date: _____

History of Disease

Yes No

Lungs

- Bronchitis
- Emphysema
- Asthma
- Chronic or A.M. Cough
- Hay Fever
- Do You Smoke? If yes, how much? _____

Vascular

- High Blood Pressure
- Chest Pain / MI / TIA
- Heart Murmur / Valve Disease
- Irregular or Fast Heart Beat
- Pacemaker
- Do you bleed easily?
- Have you ever had a blood transfusion? If yes, when? _____

Skin

- Hives
- Skin Cancer, if yes, explain. _____
- Do you have any other disease, condition or problems that we should know about?
If yes, list. _____
- Have you ever had any reaction to a local anesthetic? If yes, explain. _____
- Have you been instructed to take any prophylactic antibiotics prior to surgical procedure?
If yes, why? _____

Yes No

Systemic

- Diabetes
- Thyroid Trouble
- Kidney / Bladder Problems
- Stomach / Bowel Problems
- Hepatitis / Yellow Jaundice
- Convulsions / Epilepsy / Seizures
- Fainting
- Glaucoma
- Alcohol
- AIDS / HIV or Exposure
- Phlebitis (History)
- Joint Deformity
- (Women) Are you pregnant? If yes, expected date? _____

Recent History

Medications that you are taking: _____

Recent Operations (past 10 years): _____

Drug Allergies: _____

Describe your skin problem: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name

Date

With my consent, Dr. Kartsonis and staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Kartsonis and staff reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at 11512 Lake Mead Avenue, Suite 401, Jacksonville, FL 32256.

With my consent, Dr. Kartsonis and staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Kartsonis and staff 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.

With my consent, Dr. Kartsonis, and staff 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 statements. With my consent, Dr. Kartsonis and staff may disclose PHI to my spouse and _____ . I have the right to request that Dr. Kartsonis and staff restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that Dr. Kartsonis and staff may use and disclose my PHI to carry out TPO.

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, Dr. Kartsonis and staff may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

JOHN P. KARTSONIS, M.D., P.A.

Dermatology & Dermatologic Surgery

11512 Lake Mead Avenue, Suite 401
Jacksonville, FL 32256
(904) 731-1770

SIGNATURE ON FILE FORM FOR MEDICARE PATIENTS ONLY!

Patient Name: _____

Patient's Medicare #: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. John P. Kartsonis for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agent any information needed to determine these benefits for related services.

Patient's Signature: _____

Date: _____