Boca Raton Dermatology, P.A.
Howard A. Bueller, M.D.

5258 Linton Blvd. #306
Delray Beach, FL 33484
(561) 498-2911

Date _______________

PATIENT INFORMATION:

First Name_________________________MI______ Last Name______________________________

Address____ Apt.__________________

City____ State______ Zip_______________________

E-Mail Address____

Home Phone(___)__________Work Phone(___)_____________Cell Phone(___)______________

Date of Birth__________________Age________ Sex: □ M □ F

Marital Status: □ S □ M □ W □ D Spouse/Partner Name____________________________

Employer___________________________________ Occupation______________________________

Primary Physician_________________________ Office Phone(_____)________________________

Preferred Pharmacy_______________________________ Phone(_____)______________________

Located At (Intersection)____

Emergency Contact___________________ Relationship___________ Phone(__)_____________

HOW DID YOU HEAR ABOUT US:

□ My Doctor □ Family Member □ Friend □ Insurance Directory □ Internet □ Other

INSURANCE:

Primary Insurance Plan:____

Secondary Insurance Plan:____

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY:

I, the undersigned (patient or legal guardian), consent to medical and/or surgical treatment to be rendered by Dr. Howard A. Bueller and/or his staff. I authorize my insurance company to directly remit payment to Boca Raton Dermatology PA for medical or surgical services provided and billed. I assume financial responsibility for any services not covered by my insurance carrier.

X___________________________	X_______________________________	X_____________________
Print Patient Name	Signature	Date

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*** TO BE COMPLETED ONLY BY MEDICARE PATIENTS***

MEDICARE INFORMATION TO WHICH YOU MUST ATTEST:

1. Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job? ◻ YES ◻ NO

2. Are you covered by an HMO or PPO which makes medicare secondary? ◻ YES ◻ NO

3. Do you have Medicaid? ◻ YES ◻ NO

4. Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA administration? ◻ YES ◻ NO

5. Are you eligible for benefits under the Federal Black Lung Program? ◻ YES ◻ NO

6. Are you coming to this office for an illness , accident, or injury that is a result of an automobile accident? ◻ YES ◻ NO

7. Are you coming to this office due to Medicare Disability coverage? ◻ YES ◻ NO

8. Are you covered by the Federal End Stage Renal Disease Program? ◻ YES ◻ NO

9. Are you presently receiving Worker's Compensation? ◻ YES ◻ NO

10. Is the illness or injury you are coming to this office for the result of work-related causes? ◻ YES ◻ NO

If you answered YES to any of the above questions:

Name of Company______________________Policy#___________________ Group #___________

I request authorized Medigap (SECONDARY INSURANCE) benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

X____ X__________________________
Signature Date

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare Assignment apply.

X____ X__________________________
Signature Date

Boca Raton Dermatology, P.A.
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Patient's Name____ Date____________________

MEDICATIONS: (PLEASE ENTER ALL CURRENT MEDICATIONS, INCLUDING SUPPLEMENTS)

□NONE

ALLERGIES: (PLEASE ENTER ALL ALLERGIES TO MEDICATIONS)

□NONE

CAUTIONS: (PLEASE CHECK ALL THAT APPLY)

Do you have a pacemaker?.. □YES □NO
Do you have a defibrillator?.. □YES □NO
Have you had an artificial joint replacement?.................................. □YES □NO
If yes, when and what body locations?____
Do you have an artificial heart valve?... □YES □NO
Do you require antibiotics prior to a surgical procedure?................ □YES □NO
Do you have an allergy to latex?.. □YES □NO
Have you ever had a pneumonia vaccine?.. □YES □NO

MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

□Anxiety
□Arthritis
□Asthma
□Atrial Fibrillation
□Breast Cancer
□Colon Cancer
□COPD
□Depression
□Diabetes
□End Stage Renal Disease
□Hearing Loss
□Heart Attack
□Hepatitis
□Hypertension
□HIV/AIDS
□High Cholesterol
□Hyperthyroidism
□Hypothyroidism
□Leukemia
□Lung Cancer
□Lymphoma
□Prostate Cancer
□Prostate Enlargement
□Radiation Treatment
□Reflux Disease
□Seizures
□Stroke
□NONE
□Other____

SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

□Appendix
□Bladder
□Breast
□Colon
□Gallbladder
□Heart
□Kidney
□Liver
□Organ Transplant
□Ovaries
□Pancreas
□Rectum
□Testicles
□Uterus
□NONE
□Other____

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SKIN DISEASE HISTORY: (PLEASE CHECK ALL THAT APPLY)

□Acne	□Eczema	□Psoriasis
□Actinic Keratosis	□Flaking or Itchy Scalp	□Squamous Cell Carcinoma
□Basal Cell Carcinoma	□Hay Fever/Allergies	□NONE
□Blistering Sunburns	□Melanoma	
□Dry Skin	□Poison Ivy	

□Other____

SOCIAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

Do you smoke?	□YES	□NO	Do you drink alcohol?	□YES	□NO
Former smoker?	□YES	□NO	Do you currently drive?	□YES	□NO

WOMEN: (PLEASE CHECK ALL THAT APPLY)

□ Pregnant	□ Nursing
□ Trying to get pregnant	□ Hormone Replacement
□ Taking oral contraceptives	□ NONE

SIGNATURE

Completed by:

□ Patient □ Patient's Parent □ Guardian □ Medical Assistant

Print Name (if not patient):_______________________________

X____________________ X____________________ X____________________
Print Patient Name Signature Date

Boca Raton Dermatology, P.A.
Howard A. Bueller, M.D.

HIPAA PRIVACY PATIENT CONSENT FORM:

With my consent, Howard A. Bueller, M.D., P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Howard A. Bueller, M.D., P.A.'s 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. Howard A. Bueller, M.D., P.A. 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 Howard A. Bueller, M.D., P.A. Privacy Officer at:

Mary Chambers, Privacy Officer
Howard A. Bueller, M.D., P.A.
5258 Linton Blvd. #306
Delray Beach, FL. 33484

With my consent, Howard A. Bueller, M.D., P.A. may call my home or other designated location and leave a message on voicemail 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, Howard A. Bueller, M.D., P.A. may mail and/or email 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. I have the right to request that Howard A. Bueller, M.D., P.A. 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 to Howard A. Bueller, M.D., P.A.'s use and disclosure of 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, Howard A. Bueller, M.D., P.A. may decline to provide treatment to me.

X______________________________	X______________________________	X_______________
Print Patient Name	Signature	Date

Boca Raton Dermatology, P.A.
Howard A. Bueller MD

Patient's Name: ____ Date: ____________________

FAMILY HISTORY UPDATE: (PLEASE CHECK ALL THAT APPLY)

	MOTHER	FATHER	SISTER	BROTHER	SON	DAUGHTER
ECZEMA						
ALLERGIES						
HAY FEVER						
ASTHMA						
PSORIASIS						
RHEUMATOID ARTHRITIS						
OSTEOARTHRITIS						
LUPUS						
ALZHEIMER'S DISEASE						
PARKINSON'S DISEASE						
ALS						
MULTIPLE SCLEROSIS						
DIABETES						
HEART DISEASE						
HEART ATTACK						
STROKE						
CROHN'S DISEASE						
ULCERATIVE COLITIS						
BRCA 1 OR 2 GENE						
CANCER OF:						
BRAIN						
BREAST						
COLON						
PANCREAS						
OVARY						
UTERUS						
TESTICLE						
LYMPHOMA						
LEUKEMIA						
OTHER FAMILY HISTORY?						