John Morello MD Atlantic Boulevard Dermatology, 13111 Atlantic Blvd, Unit 4, Jacksonville, FL 32225, Tel 904 221 3100

Dearest patient: In order for us to best serve you, to file your insurance claims correctly, to be in compliance with federal and state law, and to meet requirements of Dept. of Health and Human Services. Please answer each question clearly and thoroughly. We appreciate your patience and apologize for any inconvenience.

Today's Date (mm/dd/yyyy): ________ / ________ / ______________

CONTACT INFORMATION

Last Name:______________________________ First Name: ____________________________ Middle _______________

Date of Birth (mm/dd/yyyy): _________/_________/___________ SS#____

Sex: ☐ M ☐ F Marital status (circle): Sgl. Mar. Sep. Div. Wid.

Cell Phone # ____________________________________ Home Phone # _________________________________

Email Address (REQUIRED) ____@________________________________

Home Address: ____

Home Address: city ____State_________________ Zip_________________

Emergency Contact Name: _______________________________ Phone# __________________Relationship_________

Primary Care Doctor: Last Name ____________________ First Name__________________ Phone # ______________

Pharmacy Name & location: ___________________________________ Pharmacy Tel Number______________________

Where do you work? ____ What profession?________________________

INSURANCE INFORMATION:	**Primary Insurance**	**Secondary Insurance**
Insurance Co. name:	______________________	______________________
Insured Name (Last, First)	______________________	______________________
Insured DOB (mm/dd/yyyy)	______________________	______________________
Insured SS#	______________________	______________________
Insured relationship to patient:	______________________	______________________
Insurance policy ID#	______________________	______________________

ALLERGIES TO MEDICATION: ☐ NO ☐ Yes (If yes please list)____

Describe allergy symptoms: ____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Childhood ☐ Adult ☐ Unknown

Have you been seen by Dr. Morello before? ☐ NO ☐ Yes

Reasons for todays visit: ____

Whom may we thank for referring you (Full Name):____

Are you on blood thinner medication? ☐ NO ☐ Yes (please list)____

Do you have artificial heart Valve, pacemaker, mitral valve prolapse, artificial joint ? please circle all that apply.

Pregnant? ☐ Yes ☐ NO Nursing? ☐ Yes ☐ NO Currently on Birth control pills? ☐ Yes ☐ NO

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Personal History (check all that apply)

☐ Acne
☐ Eczema
☐ Dry skin
☐ Psoriasis
☐ Abnormal moles
☐ Skin Cancer
☐ Melanoma
☐ Sinusitis
☐ Herpes Zoster
☐ Rosacea
☐ Keloid
☐ Hypertension
☐ Stroke
☐ Diabetes
☐ Hepatitis/liver disease
☐ Kidney disease
☐ Thyroid Disease
☐ HIV disease
☐ Asthma
☐ Hay fever
☐ Depression
☐ Mental illness

Do you require antibiotics before dental work? ☐ Yes ☐ NO

List previous hospital admissions, medical, surgical and mental health, including year and reason for admission:

____

Family History of Skin Cancer ☐ None ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other, specify______________

What Type of Skin Cancer? ☐ Melanoma ☐ Basal Cell ☐ Squamous Cell

Other Family History: ☐ Psoriasis ☐ Asthma ☐ Eczema ☐ Sinusitis ☐ Allergies ☐ Hay fever

Do you take any prescription or non-prescription medications including over the counter, herbal, vitamins ?

☐ NO ☐ Yes (list all, attach extra sheet if necessary) ☐ update any new medications since last visit

Name	Dosage	Frequency	Route of Administration

Demographic and Population Health Information (required by Dept of HHS)

Ethnicity: ☐ Non-Hispanic ☐ Hispanic
Language Preference: ☐ English ☐ Spanish Other: ________________________

Race: ☐ Caucasian or European American ☐ African or African American ☐ Asian or Asian American
☐ Native American or Native Alaskan ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Smoking Status:
☐ Never smoker
☐ Former smoker
☐ Current every day smoker
☐ Heavy tobacco smoker
☐ Unknown if ever smoked
☐ Smoker, current status unknown
☐ Current some day smoker
☐ Light tobacco smoker

Alcohol Use Status: ________ drinks per week, ________ drinks per occasion

Flu Vaccination Status (check box):

☐ Yes, I have received Flu Vaccine this year.

☐ NO, I have not received Flu Vaccine this year.

Pneumonia Vaccination Status (check box):

☐ Yes, I have previously received Pneumococcal Vaccine.

☐ NO, I have not previously received Pneumococcal Vaccine.

Advance Care Plan status (check box), if you are 65 years or older:

☐ Yes, I have an advance care plan and I have a surrogate decision maker.

☐ NO, I do not have an advance care plan.