Dr. Stacy Frankel: Patient Information Sheet Date:
****

Patient's Name:_____ _____ _____
(First) (Middle) (Last)

Address:_____ Apt #_____

City:_____ State:_____ Zip:_____

Primary phone #: (_____) _____-_____ (home/cell/work/other)

Other phone #: (_____) _____-_____ (home/cell/work/other)

E-mail: _____

Race:
American Indian/Alaskan Native
Asian
Black/African American
Hispanic
Native American
Other
Other Pacific Islander
White

Ethnicity:
Hispanic/Latino
Not Hispanic/Latino
Other

Language:
English
Spanish
French/French Creole
Other

Sex: _____ Marital Status: _____ Date of Birth: _____

Social Security #: _____-_____-_____

Emergency Contact:
Name:_____
Phone#: _____

Employer:_____ Work #: (_____) _____-_____

Alternate/Out of State Address:_____

Phone#: (_____) _____-_____
****

Primary Insurance Carrier:_____

ID/Policy#:_____ Group#:_____

Secondary Insurance Carrier:_____

ID/Policy#:_____ Group#:_____
****

Primary Care/Referring Physician:_____

Phone#: (_____) _____-_____ Fax#: (_____) _____-_____

Address:_____

SIGNATURE ON FILE

FOR ALL INSURANCES:

LIFETIME AUTHORIZATION

Medicare and Medicaid patient certification – patient certification authorization, release information, and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health deductibles and coinsurance.

_____	_____	_____
Date	Print Patient's Name	Patient's Signature

FOR ALL INSURANCES (Medigap, Medicare, and all insurances):

BENEFICIARY SIGNATURE AUTHORIZATION / RELEASE OF INFORMATION

_____ I request that payment of authorized insurance benefits be made on my behalf to
please initial Dr. Stacy Frankel / Florida Institute of Health for services furnished by Dr. Stacy Frankel.

_____ I authorize Dr. Stacy Frankel / Florida Institute of Health to release to my insurance company,
please initial any information, including the diagnosis and records of any treatment and/or examination rendered to me during the period of such medical and/or surgical care.

_____	_____	_____
Date	Print Patient's (Beneficiary) Name	Patient's (Beneficiary) Signature

Acknowledgement of Receipt of Privacy Notice

Stacy Frankel, MD, PA
Florida Institute of Health
2951 N.W. 49th Avenue, Suite 207
Lauderdale Lakes, FL 33313
(954) 652-0246

I herby acknowledge that I have received a copy of this medical practice's **Notice of Privacy Practices**.

_____	_____	_____
Date	Print Patient's Name	Patient's Signature

If not signed by the patient, please indicate relationship:

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary of personal representative of deceased patient

Name of Patient: _____ (please print)

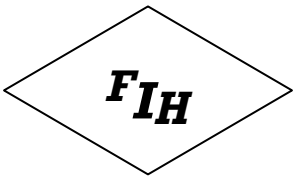
Other contact information:
The following people, other than a duly designated guardian or conservator, are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

_____	_____	(_____) _____ - _____ .
Name	Relationship	Phone number
_____	_____	(_____) _____ - _____ .
Name	Relationship	Phone number
_____	_____	(_____) _____ - _____ .
Name	Relationship	Phone number

Pharmacy:

_____	_____	(_____) _____ - _____ .
Name	Address or cross streets	Phone number

For office use only:
Signed from received by (Please Print): _____ Initials: _____
Acknowledgment refused: Efforts to obtain: _____Reasons for refusal: _____



FLORIDA INSTITUTE OF HEALTH

-American Medicine for the 21st Century-

Stacy Frankel, M.D., P.A. *Board Certified, Dermatology and Cutaneous Surgery*

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE_____/_____/_____ AGE_____

LAST NAME_____ FIRST NAME _____ MIDDLE _____

List current medical problems.

_____

_____

List past surgeries or illnesses.

_____

_____

List current medications and dosages.

_____

_____

List any allergies to medications. Please explain allergic reactions.

_____

List all serious illnesses in your immediate family. (Example: diabetes, skin cancer, etc.)

_____

Do you now or have you had any problems related to the following systems? Circle Yes or No. Please explain any Yes answers in space provided.

Artificial heart valve	Y	N
Heart murmur	Y	N
Current tobacco use	Y	N
Previous tobacco use	Y	N
History of skin cancer	Y	N
Type if known _____		

Pacemaker	Y	N
Artificial joint(s)	Y	N
Current alcohol use	Y	N
Previous alcohol use	Y	N

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other_____		

Dermatologic

Skin rashes	Y	N
Boils	Y	N
Persistent itch	Y	N
Other_____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other_____		

Allergic/Immunologic

Hay Fever	Y	N
Asthma	Y	N
Other_____		

Please read carefully and sign.

I attest that the information provided above in this document is true to the best of my knowledge. I fully understand that any incorrect or missing information can lead to missed or incorrect diagnoses.

Signature_____ Date ___/___/____