Dear Valued Patient,

I would like to take this opportunity to welcome you to Carlyle Dermatology and to thank you for choosing our organization for your healthcare needs. Our physicians and staff are committed to providing you with the highest quality healthcare in a comfortable environment. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

In order to make your first visit as pleasurable and efficient as possible, please complete our new patient forms and questionnaires prior to your scheduled appointment. You may complete these forms either by using our secure online portal (Your Health File) or downloading and faxing or mailing the completed forms to our office.

Patient's electing to self-register using our secure online portal can email their request to support@carlyledermatology.com. An invitation will be sent to the email address provided with instructions and a link to begin the registration process.

Alternatively, to view the forms listed below, you will need Adobe Reader. You may download Adobe Reader for free at http://www.adobe.com/. Please fax, mail or bring your completed forms with you to our office at the time of your visit.

New Patient Forms

1) New Patient Welcome Letter
2) Practice Policies
3) Patient Registration
4) Assignment of Benefits
5) Notice of Privacy Practices and Patients' Rights (Read)
6) Acknowledgement of Notice of Privacy Practices and Patient Consent

Notice of Privacy Practices

1) Notice of Privacy Practices and Patients' Rights (Read)
2) Acknowledgement of Notice of Privacy Practices and Patient Consent

Medical Records Request

1) Authorization for Use or Disclosure of Protected Health Information (If Applicable)

Please remember the following items for your first appointment:

1) Copies of your completed new patient forms and questionnaires
2) Insurance card(s)
3) Current medications
4) Pertinent medical records, operative reports, x-rays, and laboratory results

Also, we request you arrive at least 30 minutes prior to your initial visit so that you may be properly registered and acquainted with our facility and staff.

You are encouraged to view our web site at **www.carlyledermatology.com** as it will answer many questions you may have regarding the care and services available at Carlyle Dermatology.

9401 SW Highway 200 ◆ STE 502 ◆ Ocala, FL 34481-9650 ◆ (352) 509-6105 ◆ Fax (352) 509-6107

Thank you again for choosing Carlyle Dermatology. We look forward to seeing you.

Sincerely,

Maren C. Locke, MD, FAAD
Founder and Director

PRACTICE POLICIES

Scheduling an Appointment

Patients are seen by appointment Monday through Friday, 8:00 a.m. to 3:30 p.m. Our receptionists are available daily until 3:30 p.m. to assist with your appointment scheduling. To schedule a routine office appointment, call (352) 509-6105. Alternatively, you may request an appointment using our online health portal (Your Health File).

When scheduling an appointment, please be prepared to provide the following information:

- Patient's name
- Patient's date of birth
- Mailing address
- Daytime phone number
- Insurance information
- Name of the physician who referred you to Carlyle Dermatology, if applicable
- Reason for the appointment or a brief description of your symptoms or condition

If you are a new patient or have not visited us in more than one year, please complete our new patient forms and questionnaires prior to your scheduled appointment. You may complete these forms either by using our secure online portal (Your Health File) or downloading and faxing or mailing the completed forms to our office.

If you are not able to keep your appointment as scheduled or are going to be late, please contact our office as soon as possible. This courtesy allows us to be of service to other patients.

We try our very best to stay on schedule, although emergencies sometimes arise. If we are seriously delayed, we will attempt to notify you as soon as possible. Occasionally, we may call patients in the waiting room out of turn if they have an emergency. We ask your patience if you have to wait.

Telephone Assistance

To save you the time and expense of some follow-up visits, we may request that you call us at the office to report on your condition. Our medical staff will take the information, review your medical record with the physician and return your call at the end of the day if it is not an emergency. Should you have questions regarding your condition, medication or treatment, please call our office during normal business hours when we have access to your medical records.

If you need to have your prescription refilled, it is helpful if you know the name and phone number of your pharmacy. If you have your prescription bottle, it is best to keep it handy when speaking with our office staff.

Urgent Care and Emergencies

Should you have an urgent problem, please contact our office immediately at (352) 509-6105. Our phones are answered 24 hours a day.

In a true emergency, it is best to go to the Emergency Department of the nearest hospital where the physician on duty will initiate treatment immediately.

Referrals

If you have been referred to Carlyle Dermatology by another physician or have a primary care physician, please inform us. We will be able to keep your physician current on your diagnosis and condition.

Confidentiality

Your medical record is strictly private. We will not give out information regarding your condition to your employer, friends or relatives without your written authorization. The only exception to this is when required by law.

Insurance and Billing

Carlyle Dermatology is a provider for Medicare and most major insurance plans. We will do everything possible to ensure your insurance benefits are received by billing all primary and secondary insurances. However, your insurance is a contract between you and your carrier. To ensure that the billing process goes smoothly, please make sure our office has accurate and current insurance information. You are also responsible for any charges that are not covered by your insurance at the time of your appointment, including a co-pay, deductible or other out of pocket expenses. If necessary, our staff is happy to work with patients to set up a payment plan.

If you have questions regarding billing or which insurance plans we accept, please call us at (352) 509-6105. Questions regarding insurance coverage and benefits should be directed to your employer or insurance company.

Patients with HMO type medical insurances must contact their primary care physician to obtain authorization or referral before scheduling an appointment with a medical specialist such as a dermatologist. Patients with PPO type medical insurances are permitted to schedule appointments directly with a dermatologist or other medical specialist.

REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST	MI	☐ DR. ☐ MR. ☐ MS. ☐ MRS. ☐ MISS

DATE OF BIRTH	AGE	RACE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W ☐ SEP

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

EMAIL ADDRESS

PATIENT'S OCCUPATION	EMPLOYER	EMPLOYER PHONE ( )

SPOUSE'S LAST NAME	FIRST	MI	☐ DR. ☐ MR. ☐ MS. ☐ MRS. ☐ MISS

SPOUSE'S OCCUPATION	EMPLOYER	EMPLOYER PHONE ( )

WHY DID YOU CHOOSE OUR PRACTICE? (PLEASE CHECK ALL THAT APPLY)
☐ INSURANCE PLAN ☐ FAMILY ☐ FRIEND ☐ INTERNET ☐ YELLOW PAGES ☐ OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY #	GROUP #

SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE	POLICY #	GROUP #

SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY CARE PHYSICIAN

LAST NAME	FIRST	MI	SPECIALTY

STREET SDDRESS	CITY	STATE	ZIP CODE	OFFICE PHONE ( )

REFERRING PHYSICIAN

LAST NAME	FIRST	MI	SPECIALTY

STREET ADDRESS	CITY	STATE	ZZIP CODE	OFFICE PHONE ( )

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE	RELATIONSHIP TO PATIENT	HOME PHONE ( )	WORK PHONE ( )

PHARMACY

PHARMACY NAME (FIRST CHOICE)	LOCATION	PHONE NUMBER ( )
PHARMACY NAME (SECOND CHOICE)	LOCATION	PHONE NUMBER ( )

CERTIFICATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vantage Health, LLC or insurance company to release any information required to process my claims.

X		
	PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (SIGNATURE)	**DATE OF SIGNATURE**
	PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (PRINTED NAME)	**RELATIONSHIP IF OTHER THAN PATIENT**

ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Vantage Health, LLC and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Vantage Health, LLC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Vantage Health, LLC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Vantage Health, LLC for all covered medical services and supplies provided to me during all courses of treatment and care provided by Vantage Health, LLC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Vantage Health, LLC, and will constitute a continuing authorization, maintained on file with Vantage Health, LLC, which will authorize and allow for direct payment to Vantage Health, LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Vantage Health, LLC.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Vantage Health, LLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity if requested. The original authorization will be kept on file by Vantage Health, LLC.

X ______________________________ ______________________________

Patient/Legal Guardian/Authorized Person (Signature) Date of Signature

______________________________ ______________________________

Patient/Legal Guardian/Authorized Person (Printed Name) Relationship If Other Than Patient

X ______________________________ ______________________________

Witness (Signature) Date of Signature

NOTICE OF PRIVACY PRACTICES AND PATIENTS' RIGHTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND YOUR RIGHTS AS A PATIENT. PLEASE REVIEW IT CAREFULLY.

If you have any questions about our practices or your rights, please contact:

Privacy Officer
P.O. Box 773730
Ocala, Florida 34477-3730
(352) 861-2115
(352) 854-5726 (Fax)

This Notice of Privacy Practices, effective September 1, 2018, describes how we may use and disclose your protected health information for treatment, payment or healthcare operations, and for other purposes that are required or permitted by law. It also provides your rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

We reserve our right to revise, make new policies, or change the terms of this notice. Any revisions to our privacy practices will apply to all protected health information that we maintain at that time. We will post a notice of any revised practices in a prominent place on our premises.

The following practice locations and departments comprise Vantage Health, LLC and are covered under this Notice of Privacy Practices and Patients' Rights:

Vantage Urologic Institute

Carlyle Dermatology

Consilience, LLC

BioVantra, LLC

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

All departments and offices comprising our practice, will use, share and disclose your protected health information as necessary for quality health care, treatment, payment, and our health care operations. We will not ask you to sign a consent form for uses and disclosures that are allowed, as described in this notice. Otherwise, your written consent will be maintained on file; and you have the right to revoke your consent, unless we have taken action in reliance on your authorization. Your consent to and acceptance of our services will mean that you have consented to our use and disclosure of your protected health information, as provided in this notice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including your surgical procedures, drug study participation and/or eligibility, and all in-office ancillary healthcare services provided by our organization. This also includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose your protected health information to other outside physicians who may be treating you when we have the necessary permission from you to disclose your protected health information.

Payment: Your protected health information will be used, as needed, to obtain payment for your

health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits.

Health Care Operations: We will use and disclose your protected health information as necessary to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing activities, drug study/recruitment activities, clinical improvement, professional peer review, business management, accreditation/licensing, and conducting or arranging for other practice-related business activities.

Additionally, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. When your physician or other staff member is ready to see you, we may call you by name while you are in the waiting area. We may use or disclose your protected health information, as necessary, to contact you for appointment or other reminders or notifications.

Business Associates: At times it may be necessary for us to provide your protected health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, billing, legal services, etc. These business associates are required to properly safeguard the privacy of your information. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Appointments and Services: Our office and associated health care operations may contact you to provide appointment reminders or information about treatment alternatives, drug studies, or other health-related benefits and services that may be of interest to you.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may further use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In such case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: With your written approval, and using our best judgment, your protected health information may be disclosed to designated family, friends, and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use and disclose your protected health information in an emergency treatment situation. Should such an emergency arise, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If our physician is required by law to provide treatment and we have attempted, but have been unable, to obtain your consent, we may still use or disclose your protected health information in rendering treatment to you.

Communication Barriers: We may use and disclose your protected health information if your physician attempts to obtain your consent but is unable to do so due to substantial communication

barriers, and the physician determines, using professional judgment, that you intend to consent to such use or disclosure under the circumstances.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations, without your consent or authorization:

Required by Law/Public Health: Releases required by law and/or public health activities (e.g. disease, injury, birth/death reporting) and public health investigations;

Abuse or Neglect: Releases required for suspected child abuse or neglect, or if you are suspected of being a victim of abuse, neglect, or domestic violence;

Food and Drug Administration: Releases to the Food and Drug Administration for reporting adverse events, product defects, or for product recalls;

Employment: Releases to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;

Regulatory Agencies: Releases legally required to a government oversight agency conducting audits, investigations, or civil/criminal proceedings;

Legal Proceedings: Releases pursuant to a court order, administrative ordered subpoena or discovery request; in most cases you will have notice of such releases;

Law Enforcement: Releases to law enforcement as legally required for reporting wounds, injuries, and crimes;

Coroners and Funeral Directors: Releases to coroners and/or funeral directors according to applicable laws;

Organ Donation: Releases for organ/tissue donation or transplantation, according to your written instructions, or other legal directives;

Military Requirements: Releases for military requirements, armed forces services, or if necessary for national security or intelligence activities;

Workers' Compensation: Releases to workers' compensation agencies, as applicable to your workers' compensation benefit determinations;

Research: Releases to researchers when their research has been approved by an institutional review board; and

Inmates: Releases if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

PATIENTS' RIGHTS NOTIFICATION

You are entitled to certain rights that you may exercise as described below.

Access to Protected Health Information: You have the right to copy and/or inspect much of your protected health information that we retain on your behalf, and that is contained in a designated record set, for as long as we maintain such protected health information. A "designated record set" contains medical and billing records and any other records that your physician and our office used for making decisions about you. Your request to access your protected health information must in writing, dated, and signed by you or your legal

representative.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action, and protected health information that is subject to law that prohibits such access. In some circumstances, you may have a right to have reviewed any decision denying your request for such protected health information.

Amendments to Protected Health Information: You have the right to request in writing that your protected health information that we maintain in a designated record set, be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To qualify for consideration, your amendment request must be in writing, dated, and signed by you or your legal representative, and must state the reasons for the requested amendment/correction. Should we make an amendment/correction that you request, we may also notify others within our organization(s) for the amendment/correction of your records that they maintain.

Accounting for Disclosures of Protected Health Information: You have the right to receive an accounting of certain disclosures of your protected health information that we make, after September 1, 2018. Requests must be made in writing, dated, and signed by you or your legal representative.

Restrictions on Use and Disclosure of Protected Health Information: You have the right to request restrictions on certain of our uses and disclosures of your protected health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable and legal requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe the termination is appropriate. Should we terminate a request, we will notify you. You also have the right to terminate any restriction you impose on us, by providing our organization with a written termination, dated, and signed by you or your legal representative.

Alternative Means/Alternative Locations: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests for alternative means of communications and/or locations. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request to our Privacy Officer.

Complaints: If you believe your privacy rights have been violated, you can file a complaint with our Compliance Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Access Fees: We will impose reasonable cost-based fees for certain work and expenses that we incur at your request to provide you with access to information. Such access fees may be imposed for copying, including supplies and labor, postage, and labor in the preparation of explanations or summaries of your protected health information. Such fees will be billed to you as the result of your request for your information and you agree, herein, to pay such fees as charged.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

I acknowledge that I have received and reviewed the Notice of Privacy Practices and Patients' Rights pertaining to this office and its affiliated covered entities, and all my questions have been answered to my satisfaction.

Also, I consent to the use or disclosure of my protected health information by the Vantage Health, LLC, and all of its departments, operations, and locations for the purpose of diagnosing or providing treatment, obtaining payment for my healthcare services, or to conduct its healthcare operations that specifically includes all satellite locations, billing and administration, laboratory and pathology.

X ______________________________ ______________________________
Patient/Legal Guardian/Authorized Person (Signature) Date of Signature

______________________________ ______________________________
Patient/Legal Guardian/Authorized Person (Printed Name) Relationship If Other Than Patient

AUTHORIZATION

In compliance with HIPAA's Privacy Rule, it is the policy of this office to allow properly authorized individuals to have access to your protected health information (PHI). This authorization will remain in force until revoked in writing by the Patient. Please list below the individuals you wish to have access to your protected health information.

1 ______________________________ ______________________________
Name Relationship to Patient

2 ______________________________ ______________________________
Name Relationship to Patient

3 ______________________________ ______________________________
Name Relationship to Patient

4 ______________________________ ______________________________
Name Relationship to Patient

5 ______________________________ ______________________________
Name Relationship to Patient

Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	☐ M ☐ F	**DOB:** _____/_____/_____

PRESENT DERMATOLOGIC HEALTH CONCERN(S)

Please describe your current dermatologic problem(s) and why you are seeking consultation.

ILLNESSES (Check all that apply)

Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, include approximate date or year.

Illness	Date/Yr	Illness	Date/Yr
☐ Abdominal Aortic Aneurysm	Date/Yr:	☐ HIV/AIDS	Date/Yr:
☐ Alzheimer's Disease	Date/Yr:	☐ Hodgkin's Disease	Date/Yr:
☐ Anemia	Date/Yr:	☐ Kidney Cancer	Date/Yr:
☐ Angina	Date/Yr:	☐ Kidney Stones	Date/Yr:
☐ Asthma/Bronchitis	Date/Yr:	☐ Leukemia	Date/Yr:
☐ Bladder Cancer	Date/Yr:	☐ Lung Cancer	Date/Yr:
☐ Breast Cancer	Date/Yr:	☐ Malignant Lymphoma	Date/Yr:
☐ Cardiac Arrhythmia	Date/Yr:	☐ Mitral Valve Prolapse	Date/Yr:
☐ Cerebrovascular Accident (Stroke)	Date/Yr:	☐ Multiple Sclerosis	Date/Yr:
☐ Cervical Cancer	Date/Yr:	☐ Osteoarthritis	Date/Yr:
☐ Cholelithiasis	Date/Yr:	☐ Ovarian Cancer	Date/Yr:
☐ Colon Cancer	Date/Yr:	☐ Padget's Disease	Date/Yr:
☐ Coronary Artery Disease	Date/Yr:	☐ Parkinson's Disease	Date/Yr:
☐ Cystocele/Rectocele	Date/Yr:	☐ Penile Cancer	Date/Yr:
☐ Deep Venous Thrombosis	Date/Yr:	☐ Prostate Cancer	Date/Yr:
☐ Depression	Date/Yr:	☐ Prostate Enlargement (BPH)	Date/Yr:
☐ Diabetes	Date/Yr:	☐ Prostatitis	Date/Yr:
☐ Diverticulosis/Diverticulitis	Date/Yr:	☐ Pulmonary Tuberculosis	Date/Yr:
☐ Emphysema	Date/Yr:	☐ Seizures	Date/Yr:
☐ Erectile Dysfunction (ED)	Date/Yr:	☐ Testis Cancer	Date/Yr:
☐ Genital Condyloma	Date/Yr:	☐ Transient Ischemic Attack (TIA)	Date/Yr:
☐ Genital Herpes	Date/Yr:	☐ Thyroid Disease	Date/Yr:
☐ Glaucoma	Date/Yr:	☐ Ulcerative Colitis	Date/Yr:
☐ Gout	Date/Yr:	☐ Urinary Incontinence	Date/Yr:
☐ Heart Attack	Date/Yr:	☐ Urinary Tract Infection	Date/Yr:
☐ Heart Failure	Date/Yr:	☐	Date/Yr:
☐ Heart Murmur	Date/Yr:	☐	Date/Yr:
☐ Hepatitis	Date/Yr:	☐	Date/Yr:
☐ Hiatal Hernia	Date/Yr:	☐	Date/Yr:
☐ High Blood Pressure	Date/Yr:	☐	Date/Yr:

OPERATIONS

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Yr.

MEDICATIONS

Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.

Name of Drug	Strength	Frequency Taken	Start Date/Yr.

ALLERGIES

Please list all drug allergies including type of reaction.

Drug	Type Reaction

PERSONAL HISTORY AND HEALTH HABITS

Marital Status	☐ Married ☐ Single	☐ Divorced ☐ Separated	☐ Widow
Religion			
Occupation			
Physical Activity	☐ Non-Ambulatory	☐ Limited-Mobility	☐ Inactive
	☐ Walking	☐ Running	☐ Swimming
	☐ Aerobic Training	☐ Strength Training	☐ Recreational Activities
	☐ Other		
Dietary	☐ Regular	☐ Diabetic	☐ Weight Reduction
	☐ Low Fat	☐ Renal Failure	☐ Weight Gain
	☐ Vegetarian	☐ Gluten Free	☐ Lactose Free
	☐ Other		

Advance Directive	☐ None	☐ Living Will	☐ Surrogate
Alcohol	☐ None		
	☐ Beer (drinks/wk): ________	Duration: ________ years	Date Discontinued: ________
	☐ Wine (drinks/wk): ________	Duration: ________ years	Date Discontinued: ________
	☐ Liquor (drinks/wk): ________	Duration: ________ years	Date Discontinued: ________
Tobacco	☐ None		
	☐ Cigarette (pks/day): ________	Duration: ________ years	Date Discontinued: ________
	☐ Cigar (#/day): ________	Duration: ________ years	Date Discontinued: ________
	☐ Pipe (#/day): ________	Duration: ________ years	Date Discontinued: ________
	☐ Chew (#/day): ________	Duration: ________ years	Date Discontinued: ________
	☐ Snuff (#/day): ________	Duration: ________ years	Date Discontinued: ________
Drugs	☐ None		
	☐ Marijuana (#/day): ________	Duration: ________ years	Date Discontinued: ________
	☐ Cocaine (#/day): ________	Duration: ________ years	Date Discontinued: ________
	☐ Other (#/day): ________	Duration: ________ years	Date Discontinued: ________

FAMILY HEALTH HISTORY

☐ **No History of Familial Disease**

Relative (i.e., Father, Mother, Uncle, Sister, etc.)	**Illness** (i.e., Diabetes, Heart Disease, Prostate Cancer, etc.)

REVIEW OF SYSTEMS (Check all that apply)

General	☐ Anorexia	☐ Chills	☐ Fatigue
	☐ Fever	☐ Malaise	☐ Sweats
	☐ Weight Loss		
Eyes	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain
	☐ Eye Discharge	☐ Vision Loss	☐ Eye Irritation
Ears, Nose, and Throat	☐ Decreased Hearing	☐ Ringing in Ears	☐ Ear Pain
	☐ Hoarseness	☐ Pain with Swallowing	☐ Nose Bleeds
Cardiovascular	☐ Chest Pain	☐ Peripheral Edema	
	☐ Palpitations		
Respiratory	☐ Cough	☐ Wheezing	☐ Bloody Sputum
	☐ Shortness of Breath		
Gastrointestinal	☐ Abdominal Pain	☐ Nausea	☐ Vomiting
	☐ Diarrhea	☐ Constipation	☐ Tarry Stools
	☐ Bloody Stools		
Genitourinary	☐ Painful Urination	☐ Blood in Urine	☐ Sexual Dysfunction
	☐ Difficulty Voiding	☐ Urinary Incontinence	

Musculoskeletal	☐ Back Pain ☐ Muscle Weakness	☐ Joint Pain	☐ Joint Swelling
Skin	☐ Dryness ☐ Suspicious Lesion	☐ Itching	☐ Rash
Neurological	☐ Dizziness ☐ Seizures	☐ Weakness	☐ Tremors
Psychiatric	☐ Depression ☐ Hallucinations	☐ Anxiety	☐ Memory Loss
Endocrine	☐ Cold Intolerance ☐ Weight Change	☐ Heat Intolerance	☐ Increased Thirst
Hematologic and Lymphatic	☐ Abnormal Bruising	☐ Easy Bleeding	☐ Enlarged Lymph Nodes
Allergic and Immunologic	☐ Hay Fever	☐ Itching	☐ HIV Exposure

CERTIFICATION

The above information is true to the best of my knowledge.

X		
	Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE VANTAGE HEALTH, LLC TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION AS INDICATED BELOW:

PATIENT INFORMATION

LAST NAME	FIRST	MI
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
ADDRESS		
CITY	STATE	ZIP
DAYTIME PHONE NUMBER ( )	EVENING PHONE NUMBER ( )	

RECORD HOLDER			RECORDS MAY BE RELEASED TO		
NAME			**Vantage Health, LLC (dba Carlyle Dermatology)**		
ADDRESS			**9401 SW highway 200, STE 502**		
CITY	STATE	ZIP	**Ocala**	**FL**	**34481-9650**
PHONE ( )	FAX ( )		**(352) 509-6105**	**(352) 509- (Fax)**	

INFORMATION TO BE RELEASED

DATES OF SERVICE	☐ ALL	☐ DATE RANGE FROM: ______ / ______ / ______ TO: ______ / ______ / ______		
TYPES OF INFORMATION	☐ ALL ☐ HISTORY & PHYSICAL ☐ PROGRESS NOTES	☐ CONSULTATION REPORTS ☐ LABORATORY REPORTS ☐ PATHOLOGY REPORTS	☐ RADIOLOGY REPORTS ☐ OP/PROCEDURE REPORTS ☐ DISCHARGE SUMMARY	☐ OTHER
USE OF INFORMATION	☐ CONTINUING CARE ☐ LEGAL	☐ SECOND OPINION ☐ SCHOOL	☐ PERSONAL ☐ INSURANCE	☐ OTHER

SPECIAL CATEGORIES OF INFORMATION

YOU MUST SPECIFICALLY AUTHORIZE THE DISCLOSURE OF THE FOLLOWING TYPES OF INFORMATION. (PLEASE CHECK ALL THAT APPLY)

☐ HIV TESTING RESULTS/AIDS INFORMATION	☐ ALCOHOL AND/OR DRUG ABUSE TREATMENT	☐ PSYCHIATRIC/MENTAL HEALTH RECORDS	☐ SEXUALLY TRANSMISSIBLE DISEASES

X	
SIGNATURE PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON	**DATE OF SIGNATURE**

I UNDERSTAND THAT:

1. This authorization may be revoked in writing at any time, according to the instructions in the Vantage Health, LLC Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization is valid for one year from the date signed below.** A photocopy of this form will be considered as valid as the original.
2. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal regulations.
3. I am under no obligation to sign this authorization. My health care and payment for my health care will not be conditioned on signing this authorization.
4. I may inspect and obtain a copy of any information disclosed. I may be charged a fee of up to $1.00 per page for every page copied.
5. I will get a copy of this form after I sign it.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.

X	
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (SIGNATURE)	**DATE OF SIGNATURE**
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (PRINTED NAME)	**RELATIONSHIP IF OTHER THAN PATIENT**
X	
WITNESS (SIGNATURE)	**DATE OF SIGNATURE**