



Ricardo Mejia, MD
Ashley Syler, PA-C • Alli Rayner, PA-C

New Patient Information Form

Patient Name: _____ DOB: _____

Social Security #: _____ Sex: Male Female Non-binary

Marital Status: Single Married Widowed Other

Primary Address: _____ City: _____

Zip Code: _____ State: _____ E-mail Address: _____

Home Phone Number: _____ Cell Phone Number: _____

How did you hear about our practice? _____

Employer: _____ Occupation: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

Our office may contact you via phone, text, email or leave voicemail. If any, please name method of communication you do **NOT** want us to contact you by? _____

Do you authorize our office to discuss your medical information with family members or other individuals? Yes No If yes, please provide names and phone numbers below:

Name _____ Phone _____

NOTICE OF PATIENT PRIVACY PRACTICES CONSENT

I have been given the opportunity to read a copy of Jupiter Dermatology & Hair Restoration's NOTICE OF PATIENT PRIVACY PRACTICES. I hereby give my consent to Jupiter Dermatology & Hair Restoration to use and disclose my protected health information (PHI) to carry out treatment, obtain payment and other necessary healthcare operations.

Appointment Policy

If you are 15 minutes past your scheduled appointment time, we will do our best to accommodate you, but we cannot guarantee that you will be seen. This is dependent on the providers' schedule, if unable to accommodate, we will reschedule your appointment.

Cancellation Policy

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time. If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$50 fee that is not covered by your insurance plan.

Patient Signature _____ Date _____

Parent or Legal Guardian Signature _____ Date _____



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CONSENT FOR TREATMENT

I voluntarily give my consent for treatment and also my consent to any procedures the professional medical care providers perform in the dermatology office and deem necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injection of skin lesions, cauterization of skin lesions. Our providers will discuss in detail any procedure they plan to perform, answer all questions relating to the procedure and obtain oral and signed informed consent in the exam room prior to proceeding with services.

Patient Signature _____ **Date** _____

Parent or Legal Guardian Signature _____ **Date** _____

TELEHEALTH (VIRTUAL SERVICES) CONSENT

Telehealth/virtual services mean that you may be evaluated and treated by a healthcare provider or specialist from a distant location via electronic communication. This may include follow up visits for lab results. Since this may be different than the visit/care you are familiar with, it is important that you understand and agree to the following terms:

- Your visit will be billed to your insurance company, but you will subject to your Telehealth Benefits. This means you may be responsible for copayments, deductibles, and co-insurance amounts; it depends on your policy's benefits.
- Your treating provider will be at a different location from you. Additional medical assistants and other professional personnel may also be present in the room with the provider.

I fully understand the above and consent for Telehealth/Virtual Visits

Patient Signature _____ **Date** _____

Parent or Legal Guardian Signature _____ **Date** _____

Financial policy

I, the undersigned, understand that Jupiter Dermatology & Hair Restoration has agreed to accept Medicare and/or health insurance for payment of my bills by my signature below. I acknowledge and understand that I am fully responsible for any copayment, deductible and/or coinsurance amounts at the time of service. I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or are pre-existing, that I am responsible to pay the balance in full promptly.

Patient Signature _____ **Date** _____



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Medical History

Circle any conditions that apply:

- Arthritis, Glaucoma, Thyroid, Melanoma, HIV/AIDS (Exposure)
Chronic cough, Asthma/Bronchitis, Chest Pain, Heart Disease, Hepatitis A/B/C
Lymphoma, Squamous Cell, Basal Cell, Diabetes, Emphysema
Hypertension, Mitral Valve Prolapse, Cancer (specify what kind):

Do you have any family history of skin cancer? Yes No If so, what kind:

Please list any medical conditions we should be aware of:

Please list all medications you are currently taking:

Please list any known allergies:

Reason for today's visit:

- Do you smoke? Yes No Do you drink beer, wine or liquor? Yes No
Are you currently pregnant? Yes No Do you use/have used IV drugs? Yes No
Have you received the Flu Vaccine? Yes No Do you have an Advanced Directive? Yes
Are you allergic to latex? Yes No Do you bleed easily? Yes No
Do you have a "Do Not Resuscitate (DNR)" order? Yes No
Do your eyes ever feel uncomfortable? Yes No
Have you received the pneumococcal vaccine? Yes No
Do you require antibiotics before surgery? Yes No Do you have artificial joints/screws? Yes No
Have you ever had dental anesthesia (Novocain) ? Yes No Any adverse reaction?:

Skin Care Questionnaire

Are you interested in improving the appearance of your skin? Yes No

I am interested in obtaining more information on the following:

- Facials fillers (Contour, Sculptra, Deyne, Restylane, Juvederm, Voluma) Hand Rejuvenation
Moderate to severe facial wrinkles and folds Restore volume due to aging
CO2/Resurfx Laser/PiQo4 Sculptra
Anti-aging skin resurfacing treatment To improve facial volume
Fractional/Fraxel Lasers To improve sagging skin
Botox or Dysport
Improve the appearance of wrinkles and brow lines
Treatment of TMJ/clenching or grinding
IPL Photo-Facial/Skin Rejuvenation
To improve pigmentation/Redness/stimulate collagen
Laser Hair Removal Tattoo Removal Kybella (Neck fullness/Double chin treatment)
Vein Therapy/Sclerotherapy Blu Light (Prevent cancer lesions)
Hair care : Hair loss/Thinning/Transplant
Sunscreens (Chemical Free/Sport & Water resistant)

Are you interested in having facial treatments? Yes No

Check which treatments you have had done previously:

- Facials Microdermabrasion/Microneedling Chemical Peels None