

Shauna K. Kranendonk, M.D.
Medical History

Date: _____ Preferred Name: _____

Full Name _____

Date of Birth ___ / ___ / ___ Age ___ SS# _____ Marital Status _____

Home Phone _____ Cell Phone _____

Work Phone _____ Employer _____

Which phone number is your preferred contact number ___ H ___ C ___ W

Email
Address _____

Home Address:
Street Number _____

City/State/Zip _____

Summer Address:
Street Number _____

City/State/Zip _____

Summer Telephone Number _____

Insurance Information

Primary Insurance Company: _____

Type of Insurance: HMO ___ PPO ___ COBRA ___ GROUP ___ Individual ___

Policy Holder's Name _____ SS# _____

Relationship to patient _____ Date of Birth _____

Employer _____ Phone () _____

Secondary Insurance Company: _____

Policy Holder's Name _____ SS# _____

Relationship to patient _____ Date of Birth _____

Employer _____ Phone () _____

Referring Physician of Family/Friend

If you're not referred by a Physician or Family/Friend, how did you hear about our practice?

Race/Ethnicity _____ Natural Hair Color _____ Natural Eye Color _____

Language Spoken _____

Please describe the nature of your visit

How long have you had the present concern

MEDICATIONS: (list all prescriptions, over the counter, vitamins, herbal supplements, and topical medications you are currently using)

DRUG ALLERGIES: (list all drugs and reactions)

Do you have any ALLERGIES to LATEX, TAPE, IODINE, or BETADINE?

YES _____ NO _____

If YES please indicate which one(s) and list reactions

PERSONAL AND FAMILY HISTORY

Please check only those that apply to you or to a BLOOD relative:

Malignant melanoma Self Family Member _____
Other Type(s) of Skin Cancer Self Family Member _____
Cancer of any kind Self Family Member _____

Do you have a history of atypical/unusual moles? Yes No

Have you had any moles removed? Yes No

If pathology results are known, please indicate _____

Do you sunburn easily? _____ Have you had blistering sunburns? _____

Other skin conditions _____

Do you take antibiotics prior to any surgical procedure	YES	NO
Current tobacco use	YES	NO # of pack/week
Alcohol	YES	NO
High Blood Pressure	YES	NO
Artificial or damaged heart valve	YES	NO
Metal Plate, Artificial Joint, Implants	YES	NO
Liver disease, Hepatitis, HIV	YES	NO Indicate which
Pacemaker, defibrillator	YES	NO
History of organ transplant	YES	NO
Kidney disease	YES	NO
Diabetes	YES	NO
Seizure, Stroke, Black outs	YES	NO
Asthma, Emphysema, Lung Disease, Tuberculosis	YES	NO Indicate which

FEMALE PATIENTS: Are you currently pregnant or breast feeding? YES NO

Other Medical Conditions not listed above _____

Past surgeries and/or hospitalizations _____

For quality review purposes I agree to allow my chart to be viewed by physicians outside of this office YES NO

I grant permission for a letter to be sent to my referring physician (may be necessary in some case for insurance purposes) YES NO

Patient Signature _____ Date _____

Physician Signature _____ Date _____

**Patient Consent for Use and Disclosure
of Protected Health Information**

I hereby give my consent for **Shauna Kranendonk, MD** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Shauna Kranendonk, MD describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Shauna Kranendonk, MD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shauna Kranendonk, MD 3401 PGA Blvd. Suite 440, Palm Beach Gardens, FL 33410.

With this consent, Shauna Kranendonk, MD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Shauna Kranendonk, MD may mail to my home or other alternative 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."

With this consent, Shauna Kranendonk, MD may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Shauna Kranendonk, MD restrict how it uses or discloses my PHI to carry out TPO. 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 allow Shauna Kranendonk, MD to use and disclose 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, or later revoke it, Shauna Kranendonk, MD may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable

Kranendonk Dermatology's No-Show and Cancellation Policy

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during their visit. Since appointments with Dr. Kranendonk are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary expenditures and to contain our fees, we have implemented a No Show/Cancellation Policy for all our patients. Please be advised that you are allowed one no-show or same day cancellation appointment. We will gladly reschedule this appointment without any charge. On your second no-show or same day cancellation, you will be charged a \$75.00 fee that must be paid prior to making additional appointments. Upon your third no-show or same day cancellations, we reserve the right to terminate the patient-doctor relationship.

Please be assured that we strive to run our office as efficiently as possible in order to provide you the best care, and that this policy is in place to help us achieve that goal. We appreciate your understanding and cooperation in this matter.

Cosmetic Deposit and Cancellation Policy

All cosmetic consultations are \$100. In order to reserve an appointment time, we require that you pay a \$100 deposit. This fee will be deducted from the cost of a cosmetic treatment performed at the initial appointment, or a cosmetic treatment received within one year of the consultation. If you choose to cancel your consultation appointment and do not wish to reschedule, you must contact us at least 48 hours prior to your appointment time in order to receive full refund. The cancellation must be verified with one of our schedulers. This policy also applies to all future cosmetic appointments, and for that reason, we are required to keep this credit card number on file.

I have read the foregoing document Appointment Cancellation Policy and agree to it terms.

Date:

Patient's Signature

Shauna Kranendonk, M.D.

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY
DERMATOLOGY & DERMATOLOGIC SURGERY
3401 PGA BOULEVARD, SUITE 440
PALM BEACH GARDENS, FL 33410

TELEPHONE: (561) 820-0155
FAX: (561) 691-3281

INSURANCE WAIVER

Dear Patient:

Please be advised that all services that we provided for you in our offices will be billed to your insurance company if we are contracted with your plan. You may become the liable party should your insurance company fail to pay us for the service.

Also, please be aware of what is covered and what is not covered under your particular insurance plan. We do not pre-verify benefits for all of our patients and/or diagnostic services. If there is a service that is not covered by your insurance company, you will become the liable party should your insurance company not pay.

Due to ever growing and changing insurance markets, we are unable to verify if we are participating with your insurance company. It will be left up to you to pre-verify that we are participating with your insurance company or their networks. If we do not participate with your insurance company, you will be responsible to pay for the service being rendered at the time of service, although we will provide "Courtesy Billing" for you.

I am signing that I have read, accept and understood the above insurance waiver for all my services.

Patient Name

Date

Signature of Patient

Patient Acct Number

COSMETIC INTEREST QUESTIONNAIRE

Cosmetic issues of interest to you
(Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Botox Cosmetic
<input type="checkbox"/> AHA and Glycolic Peels
<input type="checkbox"/> Fillers: Restylane,
Radiesse, Sculptra, Juvederm
<input type="checkbox"/> Microdermabrasion/Dermal Infusion
<input type="checkbox"/> Fat Transplantation
<input type="checkbox"/> Skin Care Products
<input type="checkbox"/> Age Spots Treatment
<input type="checkbox"/> Hair Removal
<input type="checkbox"/> Acne Treatment/Acne Scarring
<input type="checkbox"/> Skin Care Advice | <input type="checkbox"/> Skin Rejuvenation (Fraxel Laser)
<input type="checkbox"/> Retin-A or Renova
<input type="checkbox"/> Facials
<input type="checkbox"/> Birthmarks
<input type="checkbox"/> Sun Damage
<input type="checkbox"/> Spider Vein Treatment
<input type="checkbox"/> Eyelash Growth/Latisse
<input type="checkbox"/> Antioxidants
<input type="checkbox"/> Sun Protection Advice
<input type="checkbox"/> Other, Please specify: _____ |
|--|--|

Please answer the following questions by circling the appropriate answer:

When looking at my face in the mirror, I believe I look:

Much younger Younger True Age Older Much Older

When looking in the mirror, I am _____ Concerned with the appearance of my wrinkles:

Not Concerned Somewhat Concerned Very Concerned

I am _____ concerned with the unevenness of my skin tone:

Not Concerned Somewhat Concerned Very Concerned

Please list any other concern you have here _____

Would you like to receive email alerts about product and procedure specials?

Yes No

If yes email address: _____