GWINNETT DERMATOLOGY, P.C.

PATIENT INFORMATION (PLEASE PRINT) ACCOUNT

LAST NAME:	FIRST & MIDDLE NAME:	NAME CALLED BY:	MARITAL STATUS M S W D SEP	DATE OF BIRTH	AGE	SEX M F

STREET ADDRESS:	CITY AND STATE:	ZIP CODE:	HOME PHONE: ( )
PATIENT'S EMPLOYER:	OCCUPATION: ☐ RETIRED ☐ STUDENT	WORK PHONE: ( )	
EMPLOYER'S STREET ADDRESS:	CITY AND STATE:	ZIP CODE:	
PATIENT'S SS#:	DRUG ALLERGIES:	PRIMARY CARE PHYSICIAN:	
SPOUSE:	SPOUSE'S SS#:	SPOUSE'S WORK PHONE: ( )	REFERRING PHYSICIAN:
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:	PHONE: ( )	OTHER FAMILY MEMBERS SEEN IN OFFICE:	

PERSON RESPONSIBLE FOR PAYMENT

LAST NAME:	FIRST & MIDDLE NAME:	RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ OTHER

COMPLETE IF PATIENT IS A MINOR OR DEPENDENT STUDENT (circle relationship)

FATHER/STEP-FATHER/GUARDIAN: LAST NAME:	FIRST & MIDDLE NAME:	SS#:	
STREET ADDRESS:	CITY AND STATE:	ZIP CODE:	HOME PHONE: ( )
EMPLOYER:	WORK PHONE: ( )		
EMPLOYER'S STREET ADDRESS:	CITY AND STATE:	ZIP CODE:	
MOTHER/STEP-MOTHER/GUARDIAN: LAST NAME:	FIRST & MIDDLE NAME:	SS#:	
STREET ADDRESS:	CITY AND STATE:	ZIP CODE:	HOME PHONE: ( )
EMPLOYER:	WORK PHONE: ( )		
EMPLOYER'S STREET ADDRESS:	CITY AND STATE:	ZIP CODE:	

PRIMARY INSURANCE

INSURANCE COMPANY NAME:	CIRCLE ONE: HMO PPO POS EPO INDEMNITY		
POLICYHOLDER'S NAME:	DATE OF BIRTH:	RELATIONSHIP OF PATIENT TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
ID#:	GROUP#:	GROUP NAME:	
ELIGIBILITY PHONE #: ( )	EFFECTIVE DATE:	EXPIRATION DATE:	CO-PAY AMOUNT:
INSURANCE CO. ADDRESS:	CITY AND STATE:	ZIP CODE:	

SECONDARY INSURANCE

INSURANCE COMPANY NAME:	CIRCLE ONE: HMO PPO POS EPO INDEMNITY		
POLICYHOLDER'S NAME:	DATE OF BIRTH:	RELATIONSHIP OF PATIENT TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
ID#:	GROUP#:	GROUP NAME:	
ELIGIBILITY PHONE #: ( )	EFFECTIVE DATE:	EXPIRATION DATE:	CO-PAY AMOUNT:
INSURANCE CO. ADDRESS:	CITY AND STATE:	ZIP CODE:	

I understand that I am financially responsible for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my visit. I will pay the charges I am responsible for today, whether it is a copayment, deductible, coinsurance or payment in full by the following method:
☐ Cash ☐ Check ☐ Visa/MC

PAYMENT AUTHORIZATION: I authorize insurance payment, if any, directly to Gwinnett Dermatology, PC. I realize I am responsible for non-covered services.

Signature (Parent, if patient is a minor) **X** ______________________ Date ______________________

INFORMATION RELEASE: I authorize Gwinnett Dermatology, PC to release to my insurance carriers or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature (Parent, if patient is a minor) **X** ______________________ Date ______________________

Medical History

Patient: ______________________________ Date: ____________________

Are you allergic to any medications? ☐ YES ☐ NO

If yes, list:

____

List all medications you are currently taking: (include over-the-counter medications)

1. ____________________ 4. ____________________ 7. ____________________
2. ____________________ 5. ____________________ 8. ____________________
3. ____________________ 6. ____________________ 9. ____________________

Do you have now, or have you ever had diseases or conditions of: (Please check **YES** or **NO**)

Vascular:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
High Blood Pressure	☐	☐	Asthma	☐	☐
Heart Attack	☐	☐	Diabetes	☐	☐
Heart Murmur	☐	☐	Hepatitis B or C	☐	☐
Irregular Heartbeat	☐	☐	Arthritis/Joint Deformity	☐	☐
Pacemaker	☐	☐	Organ Transplant	☐	☐
Artificial Heart valve	☐	☐	HIV	☐	☐
Mitral valve prolapse	☐	☐	Seizures	☐	☐
			Thyroid	☐	☐

Please answer the following questions:

- **Are you pregnant?** ☐ YES ☐ NO If YES, due date? ____________________
- Contraception? ☐ YES ☐ NO If YES, type? ____________________
- Do you smoke? ☐ YES ☐ NO If YES: ______ packs/day
- Do you drink alcohol? ☐ YES ☐ NO If YES: ______ drinks/day
- Do you use recreational drugs? ☐ YES ☐ NO If YES, what? ____________________
- Do you have any known risk factors for HIV (AIDS)/Hepatitis ☐ YES ☐ NO
- Have you ever had a reaction to local anesthesia? ☐ YES ☐ NO Explain: ____________________
- Do you bleed easily? ☐ YES ☐ NO
- Do you have artificial joint(s)? ☐ YES ☐ NO

Skin:

- When you are exposed to sun do you: ☐ Burn only ☐ Burn then Tan ☐ Tan only
- Do you use a tanning bed? ☐ YES ☐ NO If YES, how often? ____________________
- Have you ever had skin cancer? ☐ YES ☐ NO If YES, type known:____________________
- Has anyone in your family had skin cancer? ☐ YES ☐ NO If YES, who? ____________ Type? _________
- Do you have a history of any specific skin diseases? ☐ YES ☐ NO

  If YES, please list:

____

List any other disease or condition we should know about:

____

List surgical procedures you have had in the last 12 months:

____

What is your occupation? ____

Completed by: ____________________ Relationship: ____________________

☐ Medical Assistant _________ ______________________________________
(initials) Reviewed by Provider Date

I consent to treatment rendered from the provider and his/her directed medical support staff at Gwinnett Dermatology, P.C.

Signature ____

Gwinnett Dermatology, P.C.
Patient Privacy Act Notice

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction and Code Sets for transmitting data electronically
- Privacy regulation over disclosure and use of health information
- Security regulations over protection of electronic health information.

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we **will** leave a message of the practice name, telephone number, and contact on the answer machine of your residence. **Information will not be left with an unauthorized person**. If you would like to have information released to someone other than yourself, please complete the following:

I, ____________________________________, hereby authorize Gwinnett Dermatology P.C. and staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone __________________________________

Work Telephone __________________________________

Cell Phone __________________________________

Pager __________________________________

Answer machine identifying patient/household by name: Yes ____ No ____

I, _____________________________________, hereby authorize Gwinnett Dermatology, P.C. and staff to fax or mail medical information pertaining to my care to a referred physician, physical therapist, pharmacy, or referring physician, and will assume responsibility to notify your office whenever this information changes.

Please list the names of people our staff can discuss your medical care with:

	Print Name	**Contact Phone #**
Spouse	___________________________________	_________________________
Parent	___________________________________	_________________________
Other	___________________________________	_________________________

Signature of Patient/Guardian ______________________________________ **Date:** ___________________

Please sign below, acknowledging you have been offered an opportunity to review our Notice of Privacy Practices.

I, _______________________________________, have been provided a copy of Gwinnett Dermatology, P.C./Gwinnett Clinical Research Center Notice of Privacy Practices.

_______________________________________ ________________
Signature of Patient (Legal Guardian, if a minor) Date

If you choose not to sign this acknowledgement form, check the box below and initial your action.

☐ ________________

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