

**GWINNETT DERMATOLOGY, PC
PATIENT INFORMATION**

PATIENT INFORMATION (PLEASE PRINT)				ACCOUNT#		
LAST NAME	FIRST NAME & M.I.	NAME CALLED BY	MARITAL STATUS M S W D SEP	DATE OF BIRTH	AGE	SEX M F
STREET ADDRESS		CITY AND STATE	ZIP CODE	PATIENT HOME#		
PATIENT'S EMPLOYER		OCCUPATION	<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT	PATIENT CELL#		
EMPLOYER'S STREET ADDRESS		CITY AND STATE	ZIP CODE	PATIENT WORK#		
IN CASE OF EMERGENCY		EMERGENCY CONTACT #	PATIENT EMAIL			
REFERRED BY	PRIMARY CARE PHYSICIAN	OTHER FAMILY MEMBERS SEEN IN OFFICE				
PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)						
LAST NAME	FIRST NAME & MIDDLE INITIAL	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> OTHER				
STREET ADDRESS		CITY AND STATE	ZIP CODE	HOME #		
EMPLOYER				CELL #		
EMPLOYER'S STREET ADDRESS		CITY AND STATE	ZIP CODE	WORK#		
COMPLETE IF PATIENT IS A MINOR OR DEPENDENT STUDENT						
CONTACT NAME	RELATIONSHIP TO PATIENT <input type="checkbox"/> FATHER/STEP FATHER <input type="checkbox"/> MOTHER/STEP MOTHER <input type="checkbox"/> GUARDIAN			HOME #		
STREET ADDRESS		CITY AND STATE	ZIP CODE	CELL #		

PATIENT PRIVACY INFORMATION			
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 #	CELL #	WORK #	EMAIL
Gwinnett Dermatology will only leave a message on your answering machine with your permission. May we leave a message on your answer machine: Yes _____ No _____			
I hereby authorize Gwinnett Dermatology, P.C., and staff to fax or mail medical information pertaining to my care to a referred or referring healthcare provider and will assume responsibility to notify them whenever this information changes.			
PLEASE LIST THE NAMES OF PEOPLE OUR STAFF CAN DISCUSS YOUR MEDICAL CARE WITH			
SPOUSE NAME	PARENT NAME		OTHER
CONTACT PHONE#	CONTACT PHONE#		CONTACT PHONE#

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 Discover

_____ Patient Initials

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

_____ Patient Initials

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.

_____ Patient Initials

ACKNOWLEDGEMENT I acknowledge all information above is accurate.	
Signature of Patient or Legal Guardian, if a minor	Date

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE: (INSURANCE CARD WILL BE COPIED)		
INSURANCE COMPANY NAME:	CIRCLE ONE: HMO PPO POS EPO INDEMNITY	
POLICYHOLDER'S NAME:	POLICYHOLDER'S DATE OF BIRTH:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF SPOUSE CHILD OTHER
MEMBER I.D.	GROUP #	CLAIMS ADDRESS (ON BACK OF CARD)
SECONDARY INSURANCE: (INSURANCE CARD WILL BE COPIED)		
INSURANCE COMPANY NAME:	CIRCLE ONE: HMO PPO POS EPO INDEMNITY	
POLICYHOLDER'S NAME:	POLICYHOLDER'S DATE OF BIRTH:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF SPOUSE CHILD OTHER
MEMBER I.D.	GROUP #	CLAIMS ADDRESS (ON BACK OF CARD)

ACKNOWLEDGEMENT: I have reviewed the information above and acknowledge all information is current and accurate as active insurance on my / our behalf.

Date of Patient's Visit	Patient Signature	Employee Initials

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices from Gwinnett Dermatology / Gwinnett Clinical Research Center for me to keep and that I have read (or had the opportunity to read if I so chose) and understood the Notice. This acknowledgement is requested per government statute.

Patient Name (please print)	Parent or Authorized Representative (if applicable)	
Signature	Date	Relationship To Patient

HISTORY AND PHYSICAL INFORMATION

Patient _____ Date of Birth _____ Today's Date _____

Are you allergic to any medications? YES NO If YES, list: _____

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

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>

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 per day ? _____
- Do you drink alcohol ? YES NO If YES, drinks per day ? _____
- Do you use recreational drugs? YES NO If YES, what drugs? _____
- Do you have any risk factors for HIV (AIDS)/Hepatitis 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 if 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 below: _____

• List any other disease or condition we should know about: _____

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

Completed by: _____ Relationship to Patient: _____

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: _____ Date: _____

