DERMATOLOGY
Center of Atlanta

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

PROVIDER: _____

Patient Information Form

FIRST NAME	M.I.	LAST	NICKNAME	SS#	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

HOME #	CELL #	WORK # / EXT.	E-MAIL ADDRESS

LANGUAGE	RACE ☐ American Indian ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White or Caucasian ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino	SEX ☐ Male ☐ Female ☐ Other	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

PATIENT'S EMPLOYER	OCCUPATION **(indicate if student)**

NAME OF ☐SPOUSE ☐ PARENT ☐ GUARDIAN **(check one)**	PHONE #. (if different from above)

OTHER FAMILY MEMEBERS SEEN IN PRACTICE?

PRIMARY CARE PHYSICIAN	ADDRESS	PHONE NUMBER

REFERRING PHYSICIAN	ADDRESS	PHONE NUMBER

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ Insurance Co ☐ Advertisement *(where* _____*)* ☐ Internet ☐ Patient ☐ Other _____

PLEASE COMPLETE IF PATIENT IS A MINOR OR COVERED BY A PARENT'S INSURANCE PLAN

a) Father/Guardian Employer: _____ Phone # _____

b) Mother/Guardian Employer: _____ Phone # _____

EMERGENCY CONTACT	RELATION	PHONE NUMBER

PHARMACY NAME	STREET ADDRESS	CITY	PHONE NUMBER

INSURANCE INFORMATION

RESPONSIBLE PARTY ☐ Self ☐ Spouse ☐ Father / Guardian ☐ Mother / Guardian

PRIMARY INSURANCE	MEMBER I.D.#	GROUP #	INSURANCE ADDRESS	CO – PAY AMOUNT
INSURED (EMPLOYEE) NAME	DATE OF BIRTH	SS #	RELATION TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other: _____	
SECONDARY INSURANCE	MEMBER I.D.#	GROUP #	INSURANCE ADDRESS	
INSURED (EMPLOYEE) NAME	DATE OF BIRTH	SS #	RELATION TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other: _____	

PLEASE HAVE YOUR INSURANCE CARD & PHOTO ID AVAILABLE FOR COPYING AT YOUR APPOINTMENT.

FOR YOUR TEST RESULTS, PLEASE INDICATE THE BEST METHOD TO REACH YOU:

a) ☐ HOME # _____ ☐ CELL # _____ ☐ WORK # _____

I GIVE PERMISSION TO LEAVE A VOICEMAIL MESSAGE ☐ YES ☐ NO

IF UNABLE TO REACH YOU BY PHONE, MAY WE RELEASE YOUR TEST RESULTS

b) ☐ EMAIL ADDRESS _____

c) ☐ SPOUSE ☐ PARENT ☐ DAUGHTER / SON ☐ OTHER: _____

IF YOU ARE 18 OR OLDER, PLEASE LIST ANYONE ELSE WE MAY DISCUSS YOUR DIAGNOSIS/TREATMENT OR BILL WITH

NAME:_____ RELATIONSHIP _____ PHONE # _____

Missed Appointment Policy:

Your appointment time has been reserved especially for you.

- We will attempt to leave a reminder message via phone, answering machine or other methods that might be available 2 days prior to your appointment.
- Please call at least 24 hours in advance to cancel or reschedule your appointment
- A credit card number will be necessary to hold your appointment time if you have repeatedly missed appointments without notice. A $25 charge for the missed appointment will be charged only if there is no prior notice given.
- A pre-payment is required for all cosmetic or extended time appointments.
- Cosmetic and surgical appointments that are missed without prior notice are subject to a missed appointment fee of 50% of the scheduled procedure.

_____ **Initials**

Consent to photograph:

Your provider may choose to take medical photographs to be part of your medical record for purposes of comparison before and after treatment.

- I understand I will not receive payment from any party for these photographs.
- I understand that these photographs are for medical purposes only and my identity will not be disclosed other than for purposes in my medical record.

_____ **Initials**

Special Notices:

Occasionally we may offer special promotions, events, discounts or the announcement of new treatments, services, or products that you may find of interest.

☐ I would like to be notified of events or services that my doctor feels may be of interest to me. I understand that these announcements may be in letter, postcard or email form.

☐ I do not want to be notified of any special events or services.

Laboratory Fees:

I understand that all outside laboratory and pathology testing will be billed from the specific laboratory to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment.

_____ **Initials**

Privacy Policy:

I have been offered a Notice of Privacy Practices for Dermatology Center of Atlanta as required by the Health Insurance Portability and Accountability Act of l996.

_____ **Initials**

HEALTH HISTORY

This confidential record of your medical history will be kept in your patient file in our office.

Patient: _____ Birth Date: _____ Patient #: _____(not required)

Allergies: ☐ Yes _____ ☐ No Height _____ Weight _____ ☐ Male ☐ Female
(Food, Drugs, or Environment)

List any drug allergies: _____

Main Reason for Today's Visit: _____
(Body Area Affected) (For How Long?)

Past Medical History:

Medical Problems / Illnesses: _____

Surgeries and Date:_____

Present Medications: (Prescriptions & Over-the-counter): ☐ None _____
(List medications)

_____

Personal History:

Yes	No		
☐	☐	Skin cancer	(Body Area) (Date)
☐	☐	Malignant melanoma	(Body Area) (Date)
☐	☐	Diagnosed atypical (not ordinary) moles	
☐	☐	Severe skin infections	
☐	☐	Psoriasis or eczema	
☐	☐	Other skin problems: _____	
☐	☐	Have used tanning beds *(approx # of times)* _____	

Skin Type:	☐ Fair	☐ Medium	☐ Dark	
Skin Burns:	☐ Always	☐ Sometimes	☐ Never	
Skin Tans:	☐ Easily	☐ Sometimes	☐ Never	
Sunscreen Usage:	☐ Always	☐ Sometimes	☐ Never	SPF used: _____
Time Spent in Sun:	☐ Outside occupation	☐ Recreational	☐ Gardening/Yard work	
	☐ Occasionally	☐ Almost Never		

Number of Blistering Sunburns: _____

Where did you grow up *(type of climate):* _____
(Where)

Smoke/Tobacco Use: ☐ Yes _____ (Packs per day) ☐ No
Alcohol Use: ☐ Yes _____ (Drinks per week) ☐ No

Family History:

Yes	No	
☐	☐	Skin cancer (Relative) _____
☐	☐	Malignant melanoma (Relative) _____
☐	☐	Other skin problems (Describe) _____

Other Concerns:

Yes	No		Yes	No	
☐	☐	Daily Skin Care/Sun Protection	☐	☐	Laser Hair Removal
☐	☐	Wrinkles	☐	☐	Excessive Underarm Sweating
☐	☐	Uneven Skin Tone/Sun Damage	☐	☐	Information on our Aesthetic Services

Other: _____

OFFICE FINANCIAL POLICY

The following information is provided to avoid any confusion regarding payment for professional medical services.

We are committed to providing the best treatment possible to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns. For your convenience we accept Visa, MasterCard, Discover, personal checks and cash.

COST ESTIMATES: Although our fees are customary for our area, our assistants may only be able to give you a cost range over the phone. A consultation and diagnosis by the provider may be necessary to determine which procedure is best for you.

INSURANCE: Please refer to the list of insurance companies that we participate with. If you are not insured with one of these companies, we will gladly file your claim; however, you are responsible for payment in full at the time of service. If we do participate with your plan, but you do not have a current insurance card at your visit, full payment will be required until we can verify your eligibility. Please contact your insurance company if you have any questions regarding your coverage prior to your visit.

CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCE: All co-payments and deductibles must be paid at the time of service. **Some plans require only your co-payment amount for office visits, but have a deductible or co-insurance percentage that applies to any procedures performed in the office (e.g., biopsies, freezing of warts or pre-cancerous lesions, acne surgery, removal of lesions, and other office procedures).** Only your insurance plan can verify that information for you. While we do understand that some blended family situations are complicated, we avoid becoming entangled with various decree arrangements. The guardian that escorts a minor to the office will be responsible for copayment, deductible and coinsurance amounts at the time of service.

NON-COVERED OR COSMETIC SERVICES: Some services that we provide (e.g., acne surgery, cyst injections, alopecia therapy, keloid scar injections, removal of benign lesions or skin tags) may be considered "not medically necessary" by your insurance carrier. You will be responsible for payment in full if your plan considers your visit as a non-covered service. The following cosmetic procedures are not covered by insurance and must be paid at the time of service such as: Botox or other neurotoxins, dermal fillers, (e.g., Restylane, Juvederm, Perlane, Radiesse, Sculptra), sclerotherapy, cosmetic consultations, laser hair removal, vascular laser therapy, and chemical peels.

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the provider. We will also obtain a copy of your driver's license or picture ID and a current valid insurance card. If you fail to provide us with the correct insurance information or any insurance changes when they occur, you will be responsible for the charges denied by the insurance plan.

NONPAYMENT: In the event an account balance that has been determined to be your responsibility remains unpaid, a Third Party Agency will be given permission to pursue recovery of the unpaid amount and any charges relating to the collection of that owed amount, pursuant to Georgia statutory law "O.C.G.A § 13-1-11. Your account may incur a delinquency charge up to 38% of the unpaid balance. The office will not be available to you for any non-emergency care until the amount due has been paid.

MEDICARE: We are Medicare participating providers and will gladly file your Medicare and Medigap claims. You will be responsible for any annual deductible determined by your plan or for any non-covered or cosmetic charges. If no payment is received from your secondary plan within 60 days after we file a claim, you will be responsible for the balance.

MISSED APPOINTMENTS: Our office policy is to charge for missed appointments not canceled within 24 hours. Please refer to our "Appointment Policies".

RETURNED CHECK FEE: There is a $15.00 fee for checks returned by the bank for non-sufficient funds. Payment of the returned check amount and fee is required within 14 days of notification to avoid further collection actions.

Your signature below signifies that you understand our financial policies and your responsibility regarding charges incurred in this office.

SIGNATURE_____ PRINT NAME_____ DATE ____/_____/_____