GEORGIA MOUNTAIN DERMATOLOGY, LLC

PATIENT INFORMATION FORM

Date: _____

Name: _____
Last *First* *Middle Initial* *Preferred Name*

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone/Text: _____ Work: _____

Preferred Contact Method/Authorization to contact at: ☐ Home ☐ Cell/Text ☐ Work

Email: _____

Sex: ☐ M ☐ F Date of Birth: _____ SSN: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse/Parent/Guardian Name (Circle): _____ Phone: _____

Referring physician or provider: _____

Patient's Employer**:** _____ Occupation: _____

PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE: _____

Policy Holder Name: _____

Date of Birth: _____ SSN: _____

Policy Number: _____

SECONDARY INSURANCE: _____

Policy Holder Name: _____

Date of Birth: _____ SSN: _____

Policy Number: _____

MEDICARE PATIENTS

Georgia Mountain Dermatology, LLC accepts what is allowed and approved by Medicare. Your co-payment and yearly deductible are your responsibility.

I request that payment of authorized Medicare benefits be made on my behalf to Georgia Mountain Dermatology, LLC for any services furnished to me by that provider.

Signature: _____ Date: _____

PATIENT CONSENTS

1. With whom may we discuss your personal, medical or financial information?

   Name: _____ Relationship: _____ Phone: _____

   Name: _____ Relationship: _____ Phone: _____

2. Emergency Contact:

   Name: _____ Relationship: _____ Phone: _____

3. Patient Consent for Medical Photography:

   I give my consent for medical photographs to be made of me (or for the patient for whom I am the parent/legal guardian). I understand that these images will be stored in my/their private medical record with strictly controlled access as mandated by the Department of Health and Human Services' "Privacy Rule."

   Name of Patient's Guardian (if under 18): _____

4. I acknowledge I have received a copy of this practice's notice of privacy practices.

5. I hereby authorize you to leave messages regarding appointments and to inform me that diagnostic results are available. Diagnostic results are never left on a message.

6. I assign and authorize payment of all medical benefits to Georgia Mountain Dermatology, LLC for all services rendered. I understand that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges. I authorize the practice to release any medical information requested to process insurance claims for payment. A photocopy of this authorization shall be considered as effective and valid as the original.

Print Patient Name: _____ Guardian Name (if patient under 18):_____

Signature (Guardian's if under 18): _____ Date: _____

FINANCIAL POLICY

We at Georgia Mountain Dermatology, LLC have adopted the following financial policy. Please let us know if you have any questions about this policy.

Please be prepared to make payment for services you receive on the date of your treatment. If your check is returned to our office for any reason, you will be responsible for the check amount along with a service charge. Payment of these amounts must be made immediately in the form of cash, money order, or credit card.

INSURANCE: We have made prior arrangements with many insurance health plans to accept an assignment of benefits. We will file claims with the plans for which we have an agreement. Some services may not be covered under your contract. Please check with your insurance plan if you have any questions regarding which services are covered. You are responsible for services not covered by your insurance plan.

COSMETIC PROCEDURES: Payment is due in full at time of your treatment.

BILLING AND PAYMENTS: Any balances due after the insurance company payment is made will be billed to the address you have provided to us. It is your responsibility to inform us of any change in your address, phone or employment. All balances are due in full within 14 days of the billing date. If you cannot pay this balance in full within the 14 days, please contact our office to discuss payment arrangements.

PAST DUE AND DELINQUENT ACCOUNTS: If you fail to meet your financial obligations you may be reported to an outside credit bureau for collections. You will be responsible for your past due balance plus the collection agency fees.

CANCELLATION POLICY: We require a 24-hour notice to cancel or reschedule your appointment. A $25 fee will be assessed to your account for a less than 24-hour cancellation or any missed appointments.

LATE POLICY: If you are late for your appointment, we have the right to reschedule your visit so that we may best respect the time of our other scheduled patients.

I certify that I have read, understand and agree with the terms of the Georgia Mountain Dermatology Financial Policy.

Print Patient Name: _____ Patient DOB: _____

Signature (Guardian's if under 18): _____ Date: _____

PAST MEDICAL HISTORY

Current or Prior Medical Conditions (Circle all that apply)

Anxiety	Depression	Liver Disease
Arthritis	Diabetes	Lung Cancer
Asthma	Kidney Disease or Failure	Lymphoma
Atrial Fibrillation	GERD / Acid Reflux	Radiation Treatments
Bone Marrow Transplant	Hearing Loss	Stroke
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood Pressure	Thyroid Problems
COPD	High Cholesterol	Ulcerative Colitis
Coronary Artery Disease	HIV/AIDS	**OTHER** _____
Crohn's Disease	Leukemia	**NONE**

Past Surgical History (Circle and specify between the listed options)

Appendix (removal)	Kidney (biopsy, kidney stone removal)
Breast (biopsy, lumpectomy, mastectomy)	Ovaries (removal)
Breast (reduction, implants)	Prostate (biopsy, TURP/removal)
Colon (biopsy, partial removal, full removal)	Spine (fusion, laminectomy, other)
Eyes (cataracts)	Spleen (removal)
Gallbladder (removal)	Stomach (gastric band, sleeve gastrectomy)
Heart Stent (CABG)	Testicles (removal, other)
Heart Valve Replacement	Tonsils (removal)
Hernia Repair	Uterus (fibroid removal, uterine cancer, C-section, D&C)
Joint Replacement (knee, hip, shoulder)	Organ Transplant (heart, kidney, liver, lung)
OTHER _____	**NONE**

Cancer History (not including skin cancer)

Do you have history of current or prior cancer **within the past 5 years**? Specify type of cancer, year cured or ongoing, and oncologist name or practice.

_____

_____

_____

Print Patient Name: _____ Signature (Guardian's if under 18): _____

Date: _____

OTHER MEDICAL HISTORY

Height: _____ **Weight:** _____

SOCIAL HISTORY: (Check the applicable box for each category)

Cigarette Smoking: ☐ Currently smokes ☐ Former smoker ☐ Never smoker

Alcohol Use: ☐ None ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Current Medications	Dosage	Frequency

If no medications check this box ☐

I authorize Georgia Mountain Dermatology, LLC to retrieve my medication history through their e-prescribing system and then import it into my electronic record.

Allergies to Medications	Reaction to medication (rash, anaphylaxis, etc)

If no allergies check this box ☐

Pharmacy Name: _____ **Location or Phone:** _____

ALERTS: (circle all that apply)

- Allergy to latex
- Allergy to adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- Pacemaker
- Require antibiotics prior to surgical procedure
- Rapid heartbeat with epinephrine
- Pregnant or currently trying to get pregnant
- Breast feeding
- MRSA history

Do you have an Advance Care Plan? ☐ Yes ☐ No

If yes, who is your surrogate decision maker? _____

Print Patient Name: _____ **Signature (Guardian's if under 18):**_____

Date: _____

Skin History

Do you wear sunscreen? ☐ Yes ☐ No **Do you tan in a tanning bed?** ☐ Current ☐ Past ☐ Never

Do you have a family history of melanoma skin cancer? (This does not include Basal or Squamous Cell Carcinoma.)

☐ Yes ☐ No **If yes, which relative(s)?** _____

Current or Prior Skin Conditions: (Circle all that apply)

Acne	Flaking or itchy scalp
Actinic Keratoses	Itchy Skin
Blistering Sunburns	Poison Ivy
Dry Skin	Precancerous or Atypical Moles
Eczema	Psoriasis
Fever blisters or cold sores	Other _____

Skin Cancer History:

If you have had skin cancer previously but do not know which type, check this box. ☐
Otherwise, please specify below.

Basal Cell Carcinoma ☐ Yes ☐ No

Squamous Cell Carcinoma ☐ Yes ☐ No

Melanoma ☐ Yes ☐ No

If you have history of **melanoma** skin cancer, please specify the body location(s) and year(s) treated below:

_____

_____

_____

_____

Print Patient Name: _____

Signature (Guardian's if under 18): _____ Date: _____