DERMATOLOGIC SURGERY SPECALIST, PC
dba
SKIN CARE PHYSICIANS OF GEORGIA, PC
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DIPLOMATE
AMERICAN BOARD OF DERMATOLOGY
DERMATOLOGIC SURGERY

MOHS MICROGRAPHIC SURGERY
CUTANEOUS LASER SURGERY
DERMATOLOGY

FELLOW AMERICAN COLLEGE MOHS
MICROGRAPHIC SURGERY AND CUTANEOUS ONCOLOGY

PATIENT QUESTIONNAIRE/REVIEW OF SYSTEMS

Name: _____
LAST FIRST MIDDLE OR INITIAL

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Birth Date: _____ Age: ____

Sex: ___ Female ___ Male Email Address: _____

Home: _____ Cell: _____ Work: _____

Employer: _____ Marital Status: _____

Primary Care Provider: _____ Phone #: _____

Person Financially Responsible for Bill (**if minor**): _____

Address: _____ Employer: _____

Telephone: _____ Relationship: _____

PRIMARY INSURANCE:

Insured Name: _____ Relationship: _____

Insured SSN: _____ *DOB*: _____ Sex: ___M ___F

Insured Address: _____

Insured Telephone: _____ Employer: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE:

Insured Name: _____ Relationship: _____

Insured SSN: _____ *DOB*: _____ Sex: ___M ___F

Insured Address: _____

Insured Telephone: _____ Employer: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

ETHNIC BACKGROUND:

Race: _____ Ethnicity (circle one) Hispanic/Latino or Non-Hispanic

Preferred Language: _____

Pharmacy Name, Address & Phone Number: _____

DEMOGRAPHICS CONSENT FORM

PRIVACY NOTICE FORM

INITIALS DATE

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about your health care. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy simply by asking or requesting one in writing.

By signing below, you acknowledge that you have been informed that there is a privacy notice in our office and that you may acquire a written copy upon request.

PHYSICIAN ASSISTANT FORM

INITIALS DATE

As you are aware, this office has opted to utilize the services of a certified Physician's Assistant (P.A.) for those levels of the practice that have been approved by the Georgia State Board of Medical Examiners.

Your signature on this approval conveys that you are in agreement with being treated by this Physician Assistant, who is acting under supervision of a Medical Doctor.

MEDICARE AUTHORIZATION

INITIALS DATE

I authorize the holder of medical or other information to release to the Social Security Administration and Health Care Financing Administration, its intermediaries or carrier, any information needed to file a Medicare claim. I permit a copy of this authorization form to be used in place of the original, and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. **DEDUCTIBLE AND CO-INSURANCE (20% IF NO SUPPLEMENT) IS DUE AND EXPECTED AT THE TIME OF SERVICE.**

TRICARE/TRICARE PRIME/CHAMPUS INSURANCE

INITIALS DATE

If you have Tricare, Tricare Prime or Champus, please READ CAREFULLY:

We are currently in network with Tricare and Champus; however, Tricare Prime (Active-Duty members) does require a referral and/or prior authorization for which the patient is responsible for acquiring from their primary care physician.

CONSENT TO OBTAIN PRESCRIPTION HISTORY

INITIALS DATE

This consent form authorizes Skin Care Physicians of Georgia to obtain and review my prescriptions history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Skin Care Physicians of Georgia can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Skin Care Physicians of Georgia to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

*I authorize the release of medical information for services rendered to my insurance company, and also authorize payment of medical benefits to the physician. I understand that I am responsible for any amount not covered by insurance. I also consent to the taking of photographs for medical, teaching purposes and office use.

PATIENT SIGNATURE DATE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**If you are 18 years of age or older; we must have your permission to discuss your treatment, medical, or financial information, etc. with anyone *other than yourself*. If a person's name is not listed on the consent form, we cannot discuss your information with them. **

PLEASE SIGN IN ONLY ONE OF THE AREAS BELOW

I hereby give my consent for Skin Care Physicians of Georgia, P.C. and staff to review or discuss my medical treatment, lab results, pathology reports, and/or financial information with the following persons, *other than myself*. I understand that I must submit a written request to amend this list.

1. _____ Relationship: _____
(FIRST & LAST NAME) (DATE OF BIRTH)

2. _____ Relationship: _____
(FIRST & LAST NAME) (DATE OF BIRTH)

3. _____ Relationship: _____
(FIRST & LAST NAME) (DATE OF BIRTH)

4. Authorize to release to any mutual healthcare physicians or medical facilities

___Yes ___ No

I authorize **Skin Care Physicians of Georgia, P.C.** to use and disclose my protected health information (PHI) listed below **upon my request**. This includes faxing this information to designated entities or persons.

____Appointments ____Restrictions ____Medications ____Released from care

____Date of visit ____Diagnosis ____Reason for visit

Entity or person(s) authorized to receive this information:

____School/Daycare/Preschool ____Camp ____Employer ____Social Worker

____Personal Representative's Employer ____Truant Officer ____Parole Officer

____Family/Friends

This PHI is being used or disclosed for the following purposes:

____Work/School Excuse ____To verify restrictions ____Verify return to work/school

Signature: _____ Date: _____

OR

If there is no one that you wish your information to be released to, *other than yourself*, please sign below:

DO NOT RELEASE ANY INFORMATION ABOUT MY MEDICAL RECORDS OR FINANCIAL INFORMATION TO ANYONE OTHER THAN MYSELF.

Signature: _____ Date: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (office address or e-mail address). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

_____	_____	_____
Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient): _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

PLEASE FULLY COMPLETE THE REASON(S) FOR YOUR VISIT TODAY:

1. Reason for today's visit? _____
2. How long have you had this problem? _____
3. What location of your body is affected? _____
4. What are your symptoms (i.e., itching, burning, pain)? _____
5. Does anything make your problem worse? _____
6. Does anything make your problem better? _____
7. Does this problem affect your sleep? _____
8. How does this affect your life? _____
9. Have you been evaluated for this problem before? _____

   If so, by who? _____
10. What was the diagnosis given? _____
11. Did you receive any treatment? _____
12. What was the treatment and how often did you receive it? _____
13. Is there anyone in your family with similar symptoms? _____

_____ INITIAL

_____ DATE

HISTORY AND INTAKE FORM

Primary Physician: _____ Phone #: _____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Arterial Fibrillation (irregular heartbeat)
Benign Prostate Hyperplasia/ BPH
Stroke
COPD
Coronary Artery Disease
Depression
Diabetes
Covid-19
High Blood Pressure
Kidney Failure
Epilepsy

GERD
Hearing loss
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Hepatitis
Leukemia
Lymphoma
Breast Cancer
Colon Cancer
Lung Cancer
Prostate Cancer
Bone Marrow Transplant

Other: _____

_____

_____

Past Surgical History:

SURGERY	YEAR OF PROCEDURE	SURGEON

Height: _____ Weight: _____

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratosis
Dry skin
Basal Cell Skin Cancer
Poison Ivy
Precancerous moles
Eczema
History of Skin Cancer
Asthma
Hay Fever/Allergies
Melanoma
Itchy scalp
Psoriasis
Squamous Cell Skin Cancer
2nd degree Sun Burn
Other: _____

_____

_____

Do you wear sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relatives? _____

Have you had an annual Flu vaccine this year? Y / N

Have you had a pneumonia vaccine? (65 or older) Y / N

Medications: (Please list all medications)

_____

_____

_____

Allergies: (Please list all allergies)

_____

_____

Social History: (Please circle all that apply)

Currently Smoker
Former Smoker
Other _____
E-cigarette/ Vape
Never Smoked

Cautions: (Please circle all that apply)

Artificial Joints with in Past 2 Years
Pacemaker
Defibrillator
Coronary Artery Disease
High Blood Pressure
Artificial Heart Valve
HIV/AIDS
Pre-medication Prior to Procedures
Allergy to Latex
Pregnant or Planning a Pregnancy
History of Low Blood or Platelet Count
Use Oxygen
Prior Chemotherapy
Blood Thinners