SKIN CARE PHYSICIANS OF GEORGIA, PC

DAVID E. KENT, M.D. DAVID J. COHEN, M.D.
STEVEN M. KENT, M.D. HYUNJI C. SCHNEIBEL, M.D.
VICKIE M. BROWN, M.D.

DIPLOMATE
AMERICAN BOARD OF DERMATOLOGY
DERMATOLOGIC SURGERY

MOHS MICROGRAPHIC SURGERY
CUTANEOUS LASER SURGERY
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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.

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MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the use of my individually identifiable health information as described below. I understand that this authorization is voluntary and that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.

PATIENT NAME: _____ **DOB:**_____ **MEDICAL RECORD** _____

- Persons/Organizations authorized to **release** the information: _____
- Persons/Organization authorized to **receive** the information: _____

Specific description of information (including dates): _____

The patient (or their legal representative) *must read and initial* the following statements:

1. I understand that this authorization will expire in one (1) year. Initials _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have an effect on any actions taken before the organization received the revocation. Initials _____

Send revocations to: Medical Records Custodian 308 Coliseum Drive Suite 200 Macon GA 31217

TO BE COMPLETED BY THE PRACTICE:

1. Purpose of this use or disclosure is: _____
2. The information will be used in the following manner: _____
3. The practice will will not **(check one)** receive direct or indirect remuneration or compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT/LEGAL GUARDIAN

The patient or the patient's legal representative may inspect and/or copy the protected health information to be disclosed in accordance with the Practice's access policies.

The Practice does not limit its right to make a use or disclosure of your information that is required by law or permitted to aver a serious threat to the health or safety to the public.

X_____ X_____

Signature of Patient or Patient's Legal Representative Date

Printed name and relationship of patient's representative: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT BASED ON THE PROVISIONS OF THIS AUTHORIZATION.

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 #: _____

Do you have a person that can make medical decisions for you in the event you are not able to communicate yourself? Yes or No

If so, please list name and phone number_____

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