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: _____ DOB: _____ 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: _____

ETHNIC BACKGROUND
RACE: _____ ETHNICITY (CIRCLE ONE): HISPANIC/LATINO OR NON-HISPANIC
PREFERRED LANGUAGE: _____

PHARMACY NAME:_____ ADDRESS:_____

PRIMARY INSURANCE:
INSURED NAME:_____ RELATIONSHIP: _____
INSURANCE COMPANY: _____
POLICY #: _____ GROUP #: _____
INSURED SSN:_____ DOB: _____ SEX: _____F _____M
INSURED ADDRESS: _____
INSURED PHONE: _____ EMPLOYER: _____

SECONDARY INSURANCE:
INSURED NAME:_____ RELATIONSHIP: _____
INSURANCE COMPANY: _____
POLICY #: _____ GROUP #: _____
INSURED SSN:_____ DOB: _____ SEX: _____F _____M
INSURED ADDRESS: _____
INSURED PHONE: _____ EMPLOYER: _____

DEMOGRAPHICS CONSENT FORMS

_____ INITIALS DATE	**PRIVACY NOTICE** 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, 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.
_____ INITIALS DATE	**PHYSICIAN ASSISTANT FORM** 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.
_____ INITIALS DATE	**MEDICARE AUTHORIZATION** 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.**
_____ INITIALS DATE	**TRICARE/TRICARE PRIME/CHAMPUS INSURANCE** 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.
_____ INITIALS DATE	**CONSENT TO OBTAIN PRESCRIPTION HISTORY** 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 DOB

2. _____ RELATIONSHIP: _____
   FIRST & LAST NAME DOB

3. _____ RELATIONSHIP: _____
   FIRST & LAST NAME DOB

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 DESIGNED ENTITIES OR PERSONS. (CHECK ALL THAT APPLY)

- ☐ APPOINTMENTS
- ☐ DATE OF VISIT
- ☐ RESTRICTIONS
- ☐ DIAGNOSIS
- ☐ REASON FOR VISIT
- ☐ MEDICATIONS
- ☐ RELEASED FROM CARE

ENTITY OR PERSON(S) AUTHORIZED TO RECEIVE THIS INFORMATION: (CHECK ALL THAT APPLY)

- ☐ SCHOOL/DAYCARE/PRESCHOOL
- ☐ SOCIAL WORKER
- ☐ FAMILY/FRIENDS
- ☐ CAMP
- ☐ PERSONAL REPRESENTATIVE'S EMPLOYER
- ☐ EMPLOYER
- ☐ TRUANT OFFICER
- ☐ PAROLE OFFICER

THIS PHI IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSED: (CHECK ALL THAT APPLY)

☐ 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. 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 THAT 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

SKIN CARE PHYSICIANS OF GEORGIA, PC.
308 COLISEUM DRIVE, SUITE 200, MACON, GA 31217
FAX: 478-745-2623

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 regulation.

PATIENT NAME: _____ DATE OF BIRTH: _____

Persons/Organizations authorized to **release** the information: _____

Persons/Organizations 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) yea**r.** **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 avert a serious threat to health or safety to the public

_____ _____

Signature of Patient or Legal Representative **Date**

Printed Name and relationship of patient's representative: _____

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 THE 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

CHECK ALL THAT APPLY

- ☐ ACNE
- ☐ ACTINIC KERATOSIS
- ☐ DRY SKIN
- ☐ BASAL CELL SKIN CANCER
- ☐ POISON IVY
- ☐ PRECANCEROUS MOLES
- ☐ ECZEMA
- ☐ HISTORY OF SKIN CANCER
- ☐ OTHER:_____
- ☐ ASTHMA
- ☐ HAY FEVER/ALLERGIES
- ☐ MELANOMA
- ☐ ITCHY SCALP
- ☐ PSORIASIS
- ☐ SQUAMOUS CELL SKIN CANCER
- ☐ 2ND DEGREE SUN BURN
- ☐ EXCESSIVE SWEATING

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 SHOT THIS YEAR? ☐ YES ☐ NO

HAVE YOU HAD A PNEUMONIA VACCINE? (65 OR OLDER) ☐ YES ☐ NO

MEDICATIONS: (PLEASE LIST ALL MEDICATIONS)

_____

_____

_____

ALLERGIES: (PLEASE LIST ALL ALLERGIES)

_____

_____

_____

SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY)

- ☐ CURRENTLY SMOKER
- ☐ FORMER SMOKER
- ☐ OTHER: _____
- ☐ E-CIGARETTE/VAPE
- ☐ NEVER SMOKED

CAUTIONS: (PLEASE CHECK ALL THAT APPLY)

- ☐ ARTIFICIAL JOINTS WITHIN PAST 2 YEARS
- ☐ DEFIBRILLATOR
- ☐ CORONARY ARTERY DISEASE
- ☐ USE OXYGEN
- ☐ HIV/AIDS
- ☐ PRE-MEDICATION PRIOR TO PROCEDURES
- ☐ ALLERGY TO LATEX
- ☐ HISTORY OF LOW BLOOD OR PLATELET COUNT
- ☐ ARTIFICIAL HEART VALVE
- ☐ PACEMAKER
- ☐ BLOOD THINNERS
- ☐ PREGNANT OR PLANNING
- ☐ HIGH BLOOD PRESSURE
- ☐ PRIOR CHEMOTHERAPY

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 _____ NO

IF SO, PLEASE LIST NAME AND PHONE NUMBER: _____

PAST MEDICAL HISTORY: (PLEASE CHECK 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:_____