dermatology group of the carolinas

Acct:	
Appt. Date: Appt. Time: Doctor: Entered By: Verified By:	

PLEASE CORRECT/ COMPLETE INFORMATION BELOW

Name: (Circle one) Mr., Ms., Mrs., Miss, Dr., Rev.		**DOB: :**
Preferred Name:		**SSN:**
Address:		**Employer/School:**
City, State, Zip:		
Home Phone:	**Work Phone:**	**Cell Phone:**
Contact Phone #:		**Gender:**
Referring Physician:		**Primary Care Physician:**
Race:		**Preferred Language:**
Ethnicity (Circle one)**: Hispanic/Latino/a OR Not Hispanic/Latino/a**		**Email:**
Emergency Contact:	**Phone:**	**Relationship to Patient:**

***Please list <u>all</u> people with whom we are authorized to discuss and share any/all of the patient's PHI, including the patient's spouse, parents, relatives, legal guardians, school authorities, and/or other caregivers. <u>We may be unable to disclose any PHI to anyone not identified on this list, including immediate family members</u>.**

I understand that I have a right to revoke this authorization at any time by notifying Dermatology Group of the Carolinas in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)

First Name	Last Name	Relationship to Patient

Primary		Secondary	
Insurance Co.		Insurance Co.	
Insurance ID#		Insurance ID#	
Group Name or #		Group Name or #	
Employer (If Group)		Employer (If Group)	
Insured Party's Name		Insured Party's Name	
Insured Party's Address (if different from above)		Insured Party's Address (if different from above)	
Insured Party's DOB		Insured Party's DOB	
Insured Party's Soc. Sec. #		Insured Party's Soc. Sec. #	

FOR MEDICARE AND MEDICAID PATIENTS ONLY
The information given by me in applying for payment under Medicare, Medicaid, and/or Medicare Supplement is correct. I request that payment of authorized benefits under these programs be made either to me or on my behalf to Dermatology Group of the Carolinas for any service furnished to me by that physician/provider. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services to the Centers for Medicare and Medicaid Services.

FOR ALL PATIENTS
I authorize Dermatology Group of the Carolinas to release any necessary PHI to my Primary Care Physician or any Specialist Physician I am referred to for further treatment. I hereby authorize Dermatology Group of the Carolinas to release any necessary PHI to any insurance companies when making a claim on my behalf. I further authorize payment of these medical benefits to Dermatology Group of the Carolinas for these services, if applicable. I understand this authorization allows the release of all PHI in my record.

I understand the payment of any copay, coinsurance, and/or deductible is due at the time of service.
I understand I am responsible for any services rendered not covered by insurance and/or the unpaid account balance.
I understand that pathology specimans obtain may need to be sent out for additional testing.

COMMUNICATION CONSENT

May we leave a message regarding laboratory and pathology test results? Please circle: Yes or No
May we leave a message regarding your next appointment? Please circle: Yes or No

Preferred Method of Contact for appointments: Phone/Text/Email

*NOTE: If you provide your email address, you will receive an invitation to join our patient portal.

Signature of Patient (or Patient's Representative) _____ Date _____

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement
Proficiency of Language Assistance Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-704-784-5901 to find out more details.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-704-784-5901

Consent For Treatment

I am a patient at Dermatology Group of the Carolinas. By signing this form, I consent to be treated by the providers of this practice. My provider may require more facts about my health. I, Patient X. Test, agree to let the providers of this practice and staff do lab tests, screening tests, diagnostic tests, and rountine exams. I understand that no promises have been made to me about the results of any treatment or services.

CANCELLATION/NO-SHOW POLICY

In the event you are unable to attend your appointment, we request that you cancel your appointment at least **forty-eight (48) hours** prior to your scheduled appointment. Please call **704-784-5901**, option **6,** at any time to notify us of the cancellation.

Patients who fail to show for their appointment without providing at least **twenty-four (24) hours' notice**, will be considered a no-show. After a patient's third no-show, he/she could be subject to dismissal from the practice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we protect the privacy of your PHI, the permitted uses and disclosures of your PHI, and your rights regarding such use and disclosure. **By signing this form, you acknowledge that you have had an opportunity to review our Notice of Privacy Practices.**

ACCOMPANY MINOR

I hearby grant the following people (over 18 years of age) permission to bring my child for medical care and I grant the following people the authority to make medical decisions regarding my child on my behalf:

Name : _____ **Relationship:** _____

Name : _____ **Relationship:** _____

I have read and understand the above policies.

Signature of Patient (or Patient's Representative) _____ Patient Name (Please Print) _____

Account #
Patient:
Birth Date:
Age:
Doctor:

Pharmacy Information

Pharmacy Name:	
Pharmacy Phone #:	
Pharmacy Street Name:	
Pharmacy City:	
Pharmacy State:	

Medications, including over-the-counter (Yes □No □)

	Medication Name:	**Dosage**	**Notes**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Drug Allergies (Yes □No □)

	Allergy	**Reaction**	**Notes**
1.			
2.			
3.			
4.			
5.			
6.			

Patient Past Medical History (Check if applicable)		**Details**
Asthma	□	
Lung Disease (COPD)	□	
Lung Infection /Cough	□	
Allergies (seasonal)	□	
Heart Disease	□	
High Blood Pressure	□	
Heart Murmur	□	
Irregular Heartbeat	□	
Stroke	□	
Anti-Coagulation (Blood Thinners	□	
Phlebitis/ Inflamed Blood Vessels	□	
Abnormal Bleeding Disorder	□	
Liver Disease	□	

Hepatitis B or C Infection	□	
AIDS/ HIV Infection	□	
Decreased Immune System	□	
Lymph Node Enlargement	□	
Kidney Disease	□	
Diabetes	□	
Sore Joints or Muscles	□	
Arthritis	□	
Bowel Disease	□	
Depression	□	
Thyroid Disease	□	
Menstrual Cycle Irregularities	□	
Cancer (Internal) - - Please note type	□	
Sun Sensitivity /Disorders	□	
Rash	□	
Keloids (forms thick scars)	□	
Rash to Bandages or Tapes	□	
MRSA Infection	□	
Other History	□	
- No Pertinent Past Medical History	□	

Skin History		**Notes**
Actinic Keratosis "Pre cancers"	□	
Basal cell carcinoma	□	
Squamous cell carcinoma	□	
Abnormal Mole (s)	□	
Malignant Melanoma	□	
Other Lesions	□	
Acne	□	
Eczema	□	
Psoriasis	□	
Rosacea	□	
Urticaria /Hives	□	
Other Skin History	□	
- No significant skin history	□	

Surgical History		**Details**
Pacemaker/Defibrillator	□	
Heart By-Pass/Heart Stents	□	
Artificial Heart Valve	□	
Transplant	□	
Artificial Joint	□	
Cochlear Implant	□	
Vagal Nerve Stimulator	□	
Other Surgeries – 1	□	
Other Surgeries – 2	□	
None	□	

Patient Family History		**Afflicted Family Member**	**Notes**
Adopted	□		
Malignant Melanoma	□		
Other Skin Cancer	□		
Other Family History	□		
Asthma	□		
Eczema	□		
Psoriasis	□		
Seasonal Allergies	□		

- No Contributing Family History	□		

Social History

Alcohol Use
□ Does not consume alcohol
□ Consumes alcohol socially
□ Consumes alcohol daily
□ How many times in past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____ Times

Recreational Drug Use
□ Does not use recreational drugs
□ Admits to using recreational drugs

Pregnancy
□ Pregnant
□ Planning on becoming pregnant
□ Breast feeding

Tobacco History
□ I have never smoked/used smokeless tobacco
□ I am a former smoker/smokeless tobacco user:
Start date_____ Quit Date _____
□ I am a current smoker.
□ I am a current smokeless tobacco user.

Occupation: _____

Have you ever received a Pneumonia vaccine?
If yes: Month _____ Year: _____

Tanning Bed Use
□ Currently uses
□ Previously used
□ Has never used