Carolinas Dermatology Group, PA

Patient Information Form

NP Account #: ______ Dr.______

Full Name:______________________________ Sex: Male Female Marital Status: S M D W

Date Of Birth:______________ Social Security #:____________________ Driver's License #: ______________

Street Address: ______________________________ City:__________ State:______ Zip:________

Mailing Address:______________________________ City:__________ State:______ Zip:________

Home Phone#: ______________ Cell Phone #: ______________ Work Phone #: ______________

Email Address:____

Employer/School:______________________________ Occupation:____________________

Employer Address: ______________________________ City:__________ State:______ Zip:________

Emergency Contact:______________________________ Phone #: ____________________

Do You Live In A Skilled Nursing Facility: Yes No If Yes, Name of Facility: ______________________

(Information About Your Parent/Spouse)

Parent/Spouse's Full Name:____

Parent/Spouse's Employer:____

Employer's Address:______________________________ City:__________ State:______ Zip:________

Parent/Spouse DOB:______________ Social Security #:____________________ Work Phone #:______________

Primary Insurance To File

Insurance Co. Name:________________________ Relationship to Patient:____________________

Policy ID#:____ ________________________ Insured's Social Security #:____________________

Group #:______ __________ ________________ Insurance Co Address:____________________

Insured's Name:________________________ City:______________ State:______ Zip:________

Insured's DOB:________________________ Insurance Co. Phone #:____________________

Secondary Insurance To File

Insurance Co. Name:________________________ Relationship to Patient:____________________

Policy ID#:____ ________________________ Insured's Social Security #:____________________

Group #:______ __________ ________________ Insurance Co Address:____________________

Insured's Name:________________________ City:______________ State:______ Zip:________

Insured's DOB:________________________ Insurance Co. Phone #:____________________

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize this authorization allows Carolinas Dermatology Group, PA to release any information to any of my insurers or physicians as requested by any such insurer or physician.

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, GROUP POLICY BENEFITS AND OTHER HEALTH PLANS TO CAROLINAS DERMATOLOGY GROUP, PA. I HEREBY AGREE TO PAY ALL COSTS AND REASONABLE FEES IN THE EVEN THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY.

Signature:______________________________________ Date:____________________

Responsible Party's Signature (if different):______________________________________

Health Questionnaire

NP Account #: ______ Full Name:_______________

Family History (primary relative)

Non-Melanoma Skin Cancer: □ Y □ N
Melanoma □ Y □ N
Rheumatoid arthritis □ Y □ N
Lupus or other collagen vascular disease (s) □ Y □ N
Psoriasis □ Y □ N
Other genetic disease(s) □ Y □ N

Personal medical history

AIDS/HIV	□ Y □ N	Glaucoma	□ Y □ N
Bleeding disorder	□ Y □ N	Anemia	□ Y □ N
Heart condition(s) or murmurs	□ Y □ N	Diabetes	□ Y □ N
Hepatitis B/Hepatitis C/cirrhosis	□ Y □ N	Thyroid disorder	□ Y □ N
Keloid abnormal scar	□ Y □ N	Asthma	□ Y □ N
Melanoma	□ Y □ N	If yes, location and depth:	
Non-melanoma skin cancers	□ Y □ N	Pacemaker	□ Y □ N
Pregnancy ore breast feeding	□ Y □ N	Defibrillator	□ Y □ N
Rheumatoid arthritis	□ Y □ N	Tanning bed use	□ Y □ N
Joint replacement in past 2 years	□ Y □ N	Hypertension	□ Y □ N
Lupus or other collagen vascular disease (s)	□ Y □ N		

Other conditions:

Are you allergic to any medication/food material: □ Y □ N
If yes, Check/List: □ PCN □ Sulfa □ Codeine □ Others:

Current Medications:
Do you take Aspirin/Motrin: □ Y □ N If yes, Dosage:

Other Medications: ____

Name of your referring physician: ____

Name of your Primary Care Physician: ____

Authorization to Release Medical Information

I understand that my medical records are protected under State and Federal confidentiality regulations. If our staff calls to discuss your care or leave a test result, are there members of your household that we can discuss your medical information with? □ Yes □ No
If yes, please specify:
Name: ___________________________________ Relationship: ______________________
Name: ___________________________________ Relationship: ______________________
This authorization expires in: □ 6 months □ 1 year □ other (must specify): _____________________

Signature of Patient or Personal Representative: ____

Date: ______________________________

Authorization Regarding Payment and Release of Medical Information

NP Account #: ______

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to Carolinas Dermatology Group, PA. I hereby assign to Carolinas Dermatology Group, PA all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid and/or other insurance plans or payers.

I hereby authorize the release of medical information to Medicare, Medicaid and/or insurance plans or other payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers or other healthcare providers or facilities. I permit a copy of this authorization to be used.

Printed Patient/Representative's Name: ____

Relationship to Patient: ____

Patient/Representative's Signature: _______________________________________ Date: _____________

Witness Signature: ____ Date: _____________

Acknowledgement of Receipt of Our Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed and how I may obtain access to and control this information.

Printed Patient/Representative's Name: ____

Patient/Representative's Signature:____ Date:____________