Dermatology Specialists of Alabama, Florida, Georgia & Mississippi
Southeastern Dermatology Group, P.A. | Dermatology Specialists of Georgia, LLC
•Aqua Medical Spa •30A Plastic Surgery •The Hair Transplant & Restoration Center •877.231.3376

FACE SHEET / PATIENT INFORMATION – Page 1 of 2

Name_____ Date of Birth_____ Age_____ Sex_____

Mailing Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

E-mail Address_____ Social Security #_____

Employer_____ Employer Phone #_____

Marital Status_____ Occupation_____ Preferred Pharmacy_____

Emergency Contact: Name _____ Phone_____ Relationship _____

Primary Physician _____ Referring Physician_____

*Primary Insurance _____ ID Number _____

Cardholder's Name _____ Cardholder's SSN # _____

Relationship to Patient _____ Cardholder's Date of Birth_____ Cardholder's Employer_____

*Secondary Insurance _____ ID Number _____

Cardholder's Name _____ Cardholder's SSN#_____

Relationship to Patient _____ Cardholder's Date of Birth_____ Cardholder's Employer_____

Do you have an advanced care plan such as a Living Will or Power of Attorney? No___ If Yes, Specify:_____

Race: ____American Indian or Alaska Native ____Asian ____ Native Hawaiian or Other Pacific Islander ____ Hispanic
____Black or African American ____ White ____Unreported / Refused to Report ____ Other Race_____

Ethnicity: ____Hispanic or Latino ____Non-Hispanic or Latino ____Unreported / Refused to Report

Primary Language:_____Arabic ____Chinese_____English_____French_____Korean_____Spanish_____Other _____

RELEASE OF MEDICAL INFORMATION CONSENT

I, the patient or his/her legal representative, do hereby authorize Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC, to use or disclose my health-related information as outlined in the **Privacy Notice** that has been provided to me. I have received, read, and understand the information detailed in the **Privacy Notice**.

I hereby give permission to disclose, discuss and speak with the individuals listed below regarding my personal health information or treatment. I understand that unless specifically listed below, Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC cannot speak to any individual concerning my medical or financial information including, but not limited to appointments, test results, prescriptions, school or work excuses. This includes my spouse, children, siblings, or parent, if I am 18 years or older. I understand that I can amend this list at any time by submitting a request in writing.

☐ I consent to the release of my health information to the following individual(s):

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Health Information Disclosure Restriction Requests:_____

_____

Date **Signature of Patient/Authorized Representative**

FACE SHEET / PATIENT INFORMATION – Page 2 of 2

Please initial each section below to indicate you have read and understand the information:

_____**ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY**
I do, hereby, authorize payment of all insurance benefits, basic and major medical, for the services I receive, to be made directly to Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing, or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees.

_____ **STATEMENT AUTHORIZING PAYMENT BY MEDICARE AND OTHER INSURANCES**
I request that payment of authorized Medicare or other applicable private insurance benefits be paid directly to Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC for services provided under their care. I also authorize Dermatology Specialists of Georgia, LLC to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

_____ **CONSENT FOR MEDICAL SERVICES**
I authorize Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC to render treatment to me/my dependent for dermatological care/medical procedures as may be deemed necessary.

_____**DIGITAL PHOTOGRAPHY**
I authorize the medical providers and staff of Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC to take digital photographs that relate to my care. Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC will only disclose information relevant to current treatment and is authorized to use photographs for educational or publication purposes, provided my identity is protected. I may change this authorization at any time.

_____**REFERRALS/AUTHORIZATIONS**
I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. **Payment in full will be required at the time of service.**

_____**PRIVACY POLICY NOTICE**
A copy of Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC's Privacy Notice has been provided to me which outlines how my private health information may be used or disclosed and my rights related to the use and disclosure of this information. I have read and understand the information outlined in the notice.

_____**MISSED APPOINTMENTS**
Our office requires a 24-hour notice for cancellations. Failure to do so may result in a $25 fee for medical appointments and a$50 fee for cosmetic appointments.

_____**ePRESCRIBING CONSENT**
ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows our providers to see important information, such as drug interactions and your prescription history.

_____**ELECTRONIC MESSAGES**
If you have provided your email address, we would like to send you periodic news and information. This would include satisfaction surveys, information about new treatments and procedures, skin health information, physician announcements and special events. If you do not wish to receive this news, click the UNSUBSCRIBE function at the bottom of the email, and we will remove your address from this list.

_____**CONSENT FOR LAB SERVICES**
Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC uses a variety of laboratories to process biopsy specimens. It is my responsibility to ensure that these lab services are in network with my insurance company. If the lab is out of network, I will notify Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC in advance. I am responsible for any out of network fees associated with lab processing if I have not made arrangements in advance with Southeastern Dermatology Group, PA and/or Dermatology Specialists of Georgia, LLC.

_____ _____
Date **Signature of Patient/Authorized Representative** **Print Patient Name**

_____ _____
Date **Witness** **Print Authorized Individual/Relationship**

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MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Have you ever had Skin Cancer? Y / N **If yes, was it Basal Cell, Squamous Cell, or Melanoma**? (Circle all that apply)

Where was is located? How and when was it treated? _____

Do you have a family History of Basal Cell, Squamous Cell or Melanoma? _____

Do you have Dry skin, Eczema, or Psoriasis? **Y / N** – Do you have a family history of Dry skin, Eczema, or Psoriasis? **Y / N**

Do you have any Chronic Medical Conditions **or** skin conditions? (Please list all) _____

_____

Please list all current medication (including creams): _____

_____

Are you currently on any additional blood thinners? **Y / N**

Please list all drug or food allergies (including latex, lidocaine and adhesives): _____

_____

Do you have any artificial joints or valves? **Y / N** Do you have a pacemaker or Defibrillator? **Y / N**

Do you take antibiotics prior to dental procedures? **Y / N**

Please list any prior surgeries you have had (Surgery/Month/Year): _____

_____

Do you or have you ever Smoked? **Current / Former / NON** How many Cigarettes a day do you smoke? _____

Do you have a history of drug use? **Y /N**

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If 'Yes': How often did you have six or more drinks on ONE occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'yes': How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

If 'yes'; How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times a week

Do you Exercise? **Y / N** Do you have any body piercings? **Y / N** Do you have any tattoos? **Y /N**

Have you ever used a tanning bed? _____

Are you interested in cosmetic procedures? **Y / N** (please provide your email) _____

Have you ever had Botox or other cosmetic fillers? **Y / N** If yes what did you have? _____

Do you currently have a skin care regimen? **Y /N** If yes, what are you using? _____

_____

Are you receiving improvement from current regimen? **Y / N** Are you interested in a cosmetic consultation? **Y / N**