PATIENT FORM

Date: ______/_________/_________

PERSONAL INFORMATION

Full Name

Address

DOB: : ______________/______________/______________ Gender : ☐ Male ☐ Female ☐ Prefer Not to Answer

Phone Number : ______________________________

E-Mail : ______________________________

Preferred Contact Method : ☐ Phone ☐ Text ☐ Email

Status : ☐ Single ☐ Married ☐ Divorced ☐ Other

Race : ______________________________ Smoker? : ☐ Yes ☐ No

Living Will : ☐ Yes ☐ No Advanced Directive? ☐ Yes ☐ No Power of Attorney? ☐ Yes ☐ No

If Yes. Who? : _________________________

EMERGENCY CONTACT DETAILS

Contact Name : ______________________ Mobile Number : ______________________

Relationship : ______________________

I authorize the following Individual(s) to discuss my records and/or receive copies of my records.
Print names here: ______________________

INSURANCE INFORMATION

Insurance : ______________________________

ID Number : ______________________

Insurance : ______________________________

ID Number : ______________________

405 Fannin Industrial Park Blue Ridge Ga, 30513
706-309-5500 FAX: 706-309-2005
www.skincancercenternorthga.com

Mary Barber M.D

HEALTH HISTORY

Primary Care Physician

Pharmacy & City

MEDICATIONS

PLEASE PROVIDE A LIST.

Medication #1 ____ Dosage ____ Frequency ____
Medication #2 ____ Dosage ____ Frequency ____
Medication #3 ____ Dosage ____ Frequency ____
Medication #4 ____ Dosage ____ Frequency ____
Medication #5 ____ Dosage ____ Frequency ____

ALLERGIES : ☐ Yes ☐ No

LIST ALLERGIES ____ ____

MEDICAL HISTORY

PLEASE CIRCLE IF APPLICABLE.

- Epinephrine Allergy
- Latex Allergy
- Lidocaine Allergy
- Arrhythemia
- Cancer
- Diabetes
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Melanoma HX
- Skin Cancer HX
- HIV Positive
- Hypertension
- Joint Replacement
- Family HX of Melanoma
- New Moles
- Changing Moles
- Prosthetic Heart Valve
- Seizures
- Stroke
- Blood Thinners
- Pacemaker
- Pregnant/Breastfeeding
- Lymphocytic Leukemia

OTHER: Please list here:

____

____

ORIGINAL SIGNATURE ON FILE AT PHYSICIANS OFFICE

I hereby authorize Skin Cancer Center of North Georgia to release to any physician, hospital, or medical care facility any Information acquired in the course of my examination or treatment. I hereby authorize any physician, hospital, or medical care facility to provide all medical history to Skin Cancer Center of North Georgia, PC

Patient Signature ____ Date ____

Staff Signature ____ Date ____

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS & AUTHORIZATION TO RELEASE INFORMATION

- RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any medical provider examining and/or treating me to release to third payor (such as an insurance company or governmental agency, example: Blue Cross Blue Shield or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its uses in connection with determining a claim for payment for such treatment and/or diagnosis.

- PHYSICIAN INSURANCE ASSIGNMENT- the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

- MEDICARE/MEDICAID- Patients certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim, I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

- I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain In effect until revoked by me in writing.

- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

- If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

- AGREEMENT TO BE TREATED - I, the below signed person, agree to be treated by the Skin Cancer Center of North Georgia, and agree that I am responsible for payment of all services.

Patient Signature ______________________ **Date** ______________

I hereby acknowledge that I have received or have been given the opportunity to received a copy of the Skin Cancer Center of North Georgia Notice of Privacy Practices. I understand that I can request a copy of this document.

By signing below I am giving acknowledgement that I have received or have had the oppurtunity to receive the Notice of Privacy Practices.

Patient Signature ______________________ **Date** ______________

Patient **refuses** to sign acknowledgement of Notice of Privacy Practices:

Staff Signature ______________________ **Date** ______________