

Patient Information Sheet [3]--For The Skin Center & Dermatology Associates of Dothan

Complete Whole Name _____ name you wish to be called _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address _____ City _____ State _____ Zip _____

Ph: Home _____ Cell _____ (Circle best # for appt reminders etc) Marital Status: S M W D

Employed By _____ Phone # _____ (May we contact you there) Yes or No

Sex ____ Race _____ Age ____ Birthdate _____ SSN _____

Email Address _____ Referred by _____

If you wish your billing statement and or correspondence sent to an address different from your home write it here

IF PATIENT IS MINOR (RESPONSIBLE PARTY) Relationship to patient _____

Name _____ Address _____ Phone _____

Employer _____ Address _____ Phone _____

Phone _____ Date of Birth _____ SS# _____

Below please complete your primary and secondary (if you have one) insurance info. If the address, date of birth, and SSN are the same as above or the secondary is the same as primary, you do not have to repeat this information just write "same".

Primary Insurance Information

Company _____ Policy # _____ Group # _____

Policyholder Name: _____ Relationship to patient _____

Policyholder Address: _____

Policyholder Date of Birth: _____ Policyholder Social Security #: _____

Employer from whom this policy was obtained: _____

Secondary Insurance Information

Company _____ Policy # _____ Group # _____

Policyholder Name: _____ Relationship to patient _____

Policyholder Address: _____

Policyholder Date of Birth: _____ Policyholder Social Security #: _____

Employer from whom this policy was obtained: _____

Driver License Information

State _____ Number _____ Expiration Date _____

Chart# _____ Date Completed _____ Date Updated _____

Consent for Treatment and Financial Agreement

I consent to treatment necessary or desirable to the care of the patient first mentioned above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, photographs, video, or other studies that may be used by the attending doctor, physician assistant, nurse or qualified designate. I also acknowledge full responsibility for the payment of such services, and agree to pay for them at the time of service if requested. I understand that the charges made for professional services may not be covered in full by my insurance. I understand that the patient or responsible party is solely responsible for the payment of all services though my insurance may be filed. If the account becomes delinquent, I agree to pay all costs of collection, including a reasonable attorney's fee.

I, the undersigned, give Dermatology Associates of Dothan, LLC, its employees, physicians, and/or agents express prior consent to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment. We may also contact you by using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Date _____ SignatureX _____

COMMERCIAL INSURANCE EXTENDED PATIENT AUTHORIZATION:

Provider's Name: L. Terry Pynes M.D., Bret M. Johnson, M.D., Patrick Nelson, PA-C.
Provider's Address: 2431 West Main St., Ste. 501 & 303, Dothan, AL 36301; 101 Professional Lane, Enterprise, AL 36330

PAYMENT FOR SERVICES RENDERED IS TO BE MADE AS FOLLOWS:

I authorize payment of medical benefits to or on my behalf to Dermatology Associates of Dothan for services furnished to me by this physician and/or physician assistant noted above.

I authorize the release of any Medical Information necessary to process claims.

Date _____ SignatureX _____

IF PATIENT IS MINOR (Person Who Brought Patient in If Other Than Responsible Party)

Name _____ StreetAddress _____

City, State _____ Phone _____

Employer _____ Phone _____

Do you have a Cancer policy? ___Yes ___No Prescription plan? ___Yes ___No

List as much of the complete whole name, address and phone number of the following physicians as you can. If you do not want information sent to them, write NO on the name line.

Regular Physician:

Name _____ StreetAddress _____

City, State _____ Phone _____

Physician Who Sent You Here:

Name _____ StreetAddress _____

City, State _____ Phone _____

Any Other Physician to Which You Wish Records Sent

Name _____ StreetAddress _____

City, State _____ Phone _____

MEDICAL HISTORY FORM

Your Name: _____ Age: _____ Date: _____

PRESENT ILLNESS

What is the main problem and the location of the problem that you are here for today?

Length of time the problem has been present : _____

Please circle symptoms of the above problem and write any additional ones:

Itching	Stinging	Burning	Tenderness
Discomfort	Bleeding	Pain	Irritated by clothing
Interferes with normal hygiene or normal functions:			Yes No (Please circle)
Recent changes in:	Color	Texture	Shape Size

List any treatment you have had for this problem (over-the-counter, prescription, etc.)
Circle if it helped the problem, did not change or made it worse.

_____	Helped	No change	Made worse
_____	Helped	No change	Made worse
_____	Helped	No change	Made worse

MEDICATIONS AND ALLERGIES

List any medication allergies: Circle **NONE** if you have no known allergies:

 NONE _____

Are you allergic to Local Anesthetics, Numbing Medicines, Xylocaine and/or Epinephrine?
If so, please circle.

Do you use Aspirin, Aleve, Tylenol or similar pain medications? _____ (Please circle)

List medications that you take on a regular daily basis including any vitamins or over the counter products:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(OVER)

FAMILY HISTORY

Do you have a family history of: Skin Cancer Malignant Moles Psoriasis N/A

DERMATOLOGY HISTORY

Did you sunburn as a child? Yes No

Have you ever been told you had a skin cancer? Yes No If so, what type:

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma (location) _____

Have you had treatment with: Efudex Cream Freezing Cutting (please circle)

SOCIAL HISTORY

Type of work you have done : _____ Retired: Yes No

Smoke Yes No packs per day _____

Dip or chew tobacco Yes No packs per day _____

Alcohol Yes No drinks per week _____

Coffee/Caffeine Drinks Yes No cups per day _____

Do you have or have you ever had any of the following? Please circle those that apply:

AIDS	Hay fever	Radiation treatment
Anemia	Heart Murmur	Respiratory problems
Arthritis	Head injuries	Rheumatic fever
Artificial joint	Heart Disease	Rheumatism
Asthma	Hepatitis	Sinus problems
Blood disease	High Blood Pressure	Stomach problems
Cancer	Jaundice	Stroke
(type) _____	Kidney disease	Tuberculosis
Diabetes	on dialysis: yes no	Tumors
Dizziness	Liver disease	Ulcers
Epilepsy	Mental disorders	Venereal Disease
Excessive bleeding	Nervous disorders	Organ Transplant
Fainting	Pacemaker	Type: _____
Glaucoma	Pregnancy	
Growths	due date: _____	

Is your overall health : Good OK Poor (please circle)

Is your weight: Stable UP Down (please circle)

Is your eating habits: Good OK Poor (please circle)

Do you sleep: Good OK Poor (please circle)

Is your mood usually: Good Average Poor (please circle)

Hysterectomy: Yes No Tubal: Yes No

Number of children: _____

Date of last menstrual period: _____

What type of birth control do you use? _____

Are your periods Normal, Irregular, Heavy, Changing? (please circle)

Dermatology Associates of Dothan, LLC

2431 WEST MAIN STREET, SUITE 501

DOTHAN, ALABAMA 36301-1274

Telephone: (334) 793-9222

Fax: (334) 671-0322

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and healthcare operations):

2. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY :

Name _____ Phone Number _____

Name _____ Phone Number _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

4. Periodically, we may be asked to send your health information by facsimile (fax) or email for the usual treatment, payment and health operations as described in our Notice of Privacy Practices (i.e. to your insurance company, to your other physicians, etc.). If you do not want us to send your information by fax or email, please indicate this by circling NO here: NO
5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number.

*** I am fully aware that a cell phone is not a secure and private line ***

6. Messages for you to return our call may be left on your telephone answering machine or voicemail or with whomever answers your home phone unless you circle NO here: NO
With your employer or representative of your employer: NO
7. Appointment reminders may be left on your telephone answering machine or voicemail or with whomever answers your home phone unless you circle NO here: NO
With your employer or representative of your employer: NO

I, by my signature below, acknowledge that I have received a copy of the @Notice of Privacy Practices @ for the office of Dermatology Associates of Dothan, LLC.

Sign Below:

X

Signature of Patient or Guardian

Please Print Patient Name

Date

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At our practice, we are committed to treating and using protected health information about you responsibly. The Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- * Basis for planning your care and treatment.
- * Means of communication among the many health professionals who contribute to your care.
- * Legal document describing the care you received.
- * Means by which you or a third-party payer can verify that services billed were actually provided
- * Tool in educating health professionals
- * Source of data for medical research
- * Source of information for public health officials charged to improve the health of the state and the nation
- * Source of data for our planning and marketing
- * Tool by which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of our practice, the information belongs to you. You have the right to:

- * Obtain a paper copy of this notice of privacy policies upon request.
- * Inspect and copy your health records as provided by 45 CFR 164.525.
- * Amend your health record as provided by 45 CFR 164.526.
- * Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528.
- * Request confidential communications of your health information as provided by 45 CFR 164.522 and
- * Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (our practice however is not required by law to agree to a requested restriction).

Our Responsibilities

Our practice is required to:

- * Maintain the privacy of your health information
- * Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- * Abide by the terms of this notice
- * Notify you if we are unable to agree to a requested restriction, and
- * Accommodate reasonable requests you may have to communicate your health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a postal copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples of Disclosures For Treatment, Payment, and Health Operations without your written authorization, which you may revoke as provided by 45 CFR 164.508(b) (5), except to the extent that action has already been taken.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer at (334) 793-9222.

If you believe your privacy rights have been violated, you can either file a complaint with our Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The address for the OCR is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures For Treatment, Payment, And Health Operations

We will use your health information for treatment.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of your medical records that should assist them in treating you.

We will use your health information for payment.

For example:

A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.