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

Name: (Circle one) Mr., Ms., Mrs., Miss, Dr., Rev.		**DOB: :**
Preferred Name:		**SSN:**
Address:		**Gender:**
City, State, Zip:		
Home Phone: Prefered ☐	**Work Phone:** «Person_Work_Phone» Prefered ☐	**Cell Phone:** Prefered ☐
Referring Physician:		**Email** Decline ☐
Primary Care Physician: None ☐		**Preferred Language:** Decline ☐
Ethnicity (Circle one)**:** Hispanic/Latino/a OR Not Hispanic/Latino/a Decline ☐		Race: «Person_Race» Decline ☐
Emergency Contact:	Phone: **:**	**Relationship to Patient:**
May we leave a message regarding laboratory and pathology test results? **May we leave a message regarding your next appointment?**		Yes or No Yes or No

***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 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:**

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.)

Name	Relationship to Patient	HIPAA	Accompany Minor (Patient under 18 yrs of age)
		☐	☐
		☐	☐
		☐	☐

Primary		Secondary	
Insurance Co.		Insurance Co.	
Insurance ID#		Insurance ID#	
Group Name or #		Group Name or #	
Insured Parties Name		Insured Parties Name	
Insured Parties DOB		Insured Parties DOB	

		□	□

_____ **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 office will communicate by text only and I have the option to opt out at anytime.**
_____**I accept/decline that photos taken of my dermatologic issue can be used on behalf of the practice.**
_____**I understand any copay, coinsurance, and/or deductible is due at the time of service.**
_____**I am responsible for any services rendered not covered by insurance and/or the unpaid account balance.**
_____**I understand that pathology specimens obtained may need to be sent out for additional testing.**

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 agree to let the providers of this practice and staff do lab tests, screening tests, diagnostic tests, and routine exams. I understand that no promises have been made to me about the results of any treatment or services either in office or virtually.

CANCELLATION/NO-SHOW POLICY

_____In the event you are unable to attend your appointment, we require that you cancel your appointment at least Twenty-Four (24) business hours prior to your scheduled appointment. Cancellation within 24 hours will result in a late cancel. Two late cancels count as a no-show.

_____Patients who fail to show for their appointment will be considered a no-show and may be charged a $25.00 fee. After a third no-show, the patient 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.

_____ _____

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

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, areavailable 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

dermatology group of the carolinas

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**
Abnormal Bleeding Disorder	□	
AIDS/ HIV Infection	□	
Allergies (seasonal)	□	
Anti-Coagulation (Blood Thinners	□	
Arthritis	□	
Asthma	□	
Bowel Disease	□	
Cancer (Internal) - - Please note type	□	
Decreased Immune System	□	
Depression	□	
Diabetes	□	
Heart Disease	□	
Heart Murmur	□	
Hepatitis B or C Infection	□	
High Blood Pressure	□	
Irregular Heartbeat	□	
Keloids (forms thick scars)	□	
Kidney Disease	□	
Liver Disease	□	
Lung Disease (COPD)	□	
Lung Infection /Cough	□	
Lymph Node Enlargement	□	
Menstrual Cycle Irregularities	□	
MRSA Infection	□	
Other History	□	
Phlebitis/ Inflamed Blood Vessels	□	
Rash	□	
Rash to Bandages or Tapes	□	
Sore Joints or Muscles	□	
Stroke	□	
Sun Sensitivity /Disorders	□	
Thyroid Disease	□	
- 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

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.

Tanning Bed Use

☐ Currently uses

☐ Previously used

☐ Has never used

Occupation: _____

Date Completed: _____