DATE

ADVANCED DERMATOLOGY & SKIN CARE CENTRE

Thomas Bender MD Ronald Johnston MD Alan Stanford MD
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Greg Sharp PA-C Jessica Davis PA-C Kellie Toth PA-C Erin Risco CRNP Heather Dunn CRNP

CIRCLE ALL THAT APPLY **NEW PATIENT** **ESTABLISHED/RETURNING PATIENT** **REFERRED** **WORK COMP**

PATIENT INFORMATION - Circle Applicable Answers

Patient's FIRST Name, MI:			Patient's LAST Name:
Street Address: No PO Box			◯Home ◯Cell ◯Work Primary Phone #: ( )
City:	State:	Zip:	◯Home ◯Cell ◯Work Secondary Phone #: ( )
SS#:	Marital Status: M / S / D / W		E-mail:
Date of Birth:	Gender: M F		Preferred Pharmacy Advanced Care Pharmacy Other:
Employment Status: Full time Part time Retired Student N/A			Referred by: Physician Web Site Insurance Company Family/Friend/Patient (name)
Occupation:			Does your insurance require referrals? Yes / No
Company or School Name:			Did your physician refer you to us? Yes / No
Circle Race: African-American Asian Caucasian Hispanic Other			Referring Physician Full Name:
Ethnicity: Cuban Not Hispanic or Latino Other:			Primary Care Physician Full Name:
Language: English Spanish Other:			Physically Impaired: No Hearing Vision Other:
Are you currently receiving Hospice/Home Health Care? NO YES ☞			Hospice/Home Health Care Company Name

EMERGENCY CONTACT:

Name (First, Last):	Name (First, Last):
◯Home ◯Cell ◯Work Contact#: Relationship Self Spouse Child Other	◯Home ◯Cell ◯Work Contact #: Relationship Self Spouse Child Other

OTHER THAN PATIENT - PERSON RESPONSIBLE FOR ACCOUNT BALANCES – COMPLETE REQUIRED INFORMATION INCLUDING MAILING ADDRESS

FIRST Name, MI:			LAST Name:	
Street Address: No PO Box			◯Home ◯Cell ◯Work Primary Phone #: ( )	
City:	State:	Zip:	Date of Birth:	Gender: M F

IF OTHER THAN PATIENT - COMPLETE REQUIRED INFORMATION BELOW ONLY IF WE ARE TO FILE YOUR INSURANCE

PRIMARY INS. SUBSCRIBER/CARDHOLDER		Circle Relationship to Patient: Self Spouse Child Other	
Primary Ins. Name:			Co-pay Amt
Effective Date:	Group #:		Policy/ID #:
Subscriber's Name: REQUIRED TO FILE		Subscriber's DOB: REQUIRED TO FILE	Gender: M F

SECONDARY INSURANCE -- COMPLETE INFORMATION BELOW

SECONDARY INS. SUBSCRIBER/CARDHOLDER		Circle Relationship to Patient: Self Spouse Child Other	
Secondary Ins. Name:			Co-pay Amt
Effective Date:	Group #:		Policy/ID #:
Subscriber's Name: REQUIRED TO FILE		Subscriber's DOB: REQUIRED TO FILE	Gender: M F

edited 8/8/2017
edited 3/6/2017
developed 9/4/2014
Y:REGDOC:2017:17REGDOC

Messages/Voice If I am unreachable, Advanced Dermatology physicians or staff ☐ may ☐ may NOT leave messages

PERSONAL RELEASE OF INFORMATION – You consent to verbally releasing authorized contacts of your medical information to Advanced Dermatology employees. You may also elect to RESTRICT OR ALLOW Advanced Dermatology from discussing medical information including but not limited to appointments, treatments, diagnosis, prognosis, medications, with the following people listed. **PLEASE INDICATE BELOW:**

☐ **RESTRICTED – DO NOT RELEASE INFORMATION** ☐ **ALLOW – RELEASE INFORMATION TO PERSON(S) BELOW**

YOU MUST LIST FULL NAMES OF EACH PERSON(S)

PATIENT RESPONSIBILITY – Our physicians participate in many insurance plans and managed health care programs. Our office will submit a claim for services rendered for patients participating in those plans for which our physicians are providers. *Provide our office with accurate and complete insurance information. You are responsible for payment of any resulting denied claims. *Federal (Red Flag Rules) prevent us from filing to insurance without proof of identification. We will mot bill your insurance carrier. *Present photo ID and insurance card(s) to every office visit. We will not bill your insurance carrier without valid photo ID. *Pay all amount(s) due, including but not limited to balances, co-pay, coinsurance and/or deductible prior to each visit. Payment can be made by cash, check or credit card, or a payment plan may be arranged.

REFERRALS/AUTHORIZATIONS – I understand it is my responsibility to request & to notify Advanced Dermatology of any referrals or prior authorizations required by MY insurance company. If I do not have the correct authorization/referral my visit may be rescheduled or I will be responsible for payment for all costs of treatment.

CONSENT TO MEDICAL SERVICES – I authorize Advanced Dermatology to render treatment to me/my dependents for Dermatological care as may be deemed necessary. I understand any procedure including but not limited to laser treatments, cryotherapy, biopsy, chemical peel; may result in discoloration or scarring; the risk is significantly increased with sun exposure 4 weeks prior to treatment. I understand I am to notify & return to clinic if any lesion or rash does not improve and resolve within 2 weeks for further examination/treatment. I understand surgical procedures including repair may be assisted/performed by a surgical RN or CRNP.

DIGITAL PHOTOGRAPHY – I authorize physicians and staff of Advanced Dermatology to take digital photographs that relate to my care. Advanced Dermatology will only disclose information relevant to MY treatment. Advanced Dermatology may use images that do not disclose identity in professional publications, teaching purposes, or textbooks unless stated otherwise.

PERSONAL PROPERTY – I understand & agree to Advanced Dermatology, physicians and staff harmless from any and all liability and relieve Advanced Dermatology, from any and all responsibility for loss or damage of any personal property, valuables, money or any other personal belongings located in or on the premises.

MISSED APPOINTMENTS – Our office requires 24-hour notice for cancellations/appointment/procedure rescheduling. Failure to do so may result in a $30 fee for medical appointments and a $50 fee for cosmetic appointments.

ADVANCED CARE PHARMACY – FINANCIAL DISCLOSURE TO PATIENTS – This notice informs you that Gulf Coast Dermatology & Skin Care Centre DBA Advanced Dermatology & Skin Care Centre has ownership interest in Advanced Care Pharmacy. Physicians who have ownership interest in Advanced Dermatology & Skin Care Centre may indirectly receive compensation for prescriptions you have filled at this entity or other items or products you purchase. You have a choice in pharmacies and are not obligated to use this pharmacy.

PRIVACY POLICY NOTICE – I understand I may request a copy of Advanced Dermatology's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted by federal law.

E-RX – I understand as part of my electronic health record; Advanced Dermatology will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my primary pharmacy provider.

SURESCRIPTS PRESCRIPTION NETWORK DATABASE – I authorize Advanced Dermatology & Skin Care Centre to access my Surescripts Medication history in order to make more informed clinical decisions regarding my healthcare. I understand this information will become part of my electronic health record. Surescripts Policy is available upon request.

STATEMENT TO PERMIT PAYMENT OF BENEFITS TO PROVIDER – I hereby assign and authorize payment of my insurance benefits, including authorized Medicare benefits, sick benefits, injury benefits due because of liability of a third party, or proceeds of all claims resulting from liability of third party, payable by any party, organization directly to Advanced Dermatology & Skin Care Centre to release any medical or other information for the purpose of processing claims to my insurance carriers, including Health Care Financing Administration and future insurance changes. This includes information as defined by and for the purposes outlined in the Privacy Notice. I have read and understand all of the above. I understand that in the event I do not pay for services rendered and amounts become delinquent, I am obligated for all costs including collection, court and attorney fees.

I permit a copy of this authorization to be used in the place of the original

Advanced Dermatology aims to provide exemplary patient care during each and every interaction. Your satisfaction is our primary concern. If you have any issues or concerns notify us by email info@AdvancedDermClinic.com. Thank you for entrusting Advanced Dermatology with all of your skin care needs.

_____

Signature of Patient or Authorized Representative Date

_____

Witness Signature Date

Medical History

ADVANCED DERMATOLOGY & SKIN CARE CENTRE

Name: _____ Date of Birth: _____

Medications

List all current medications:

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement
- ☐ Kidney: Biopsy, stone removal, Nephrectomy
- ☐ Liver: Hepatectomy, Transplant
- ☐ Live: Shunt
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Ovaries: Endometriosis

- [ ] Ovaries (Oophorectomy): Ovarian Cancer
- [ ] Ovaries (Oophorectomy): Ovarian Cyst
- [ ] Ovaries: Tubal Ligation
- [ ] Pancreas: Pancreatectomy
- [ ] Postate (Prostatectomy): Prostate Biopsy
- [ ] Prostate (Prostatectomy: Prostate Cancer
- [ ] Prostate (Prostatectomy): TURP
- [ ] Rectum: APR
- [ ] Rectum: Low Anterior Resection
- [ ] Skin: Basal Cell Carcinoma
- [ ] Skin: Melanoma
- [ ] Skin: Skin Biopsy
- [ ] Skin: Squamous Cell Carcinoma
- [ ] Spleen (Splenectomy)
- [ ] Testicles (Orchiectomy)
- [ ] Uterus (Hysterectomy): Fibroids
- [ ] Uterus (Hysterectomy): Uterine Cancer
- [ ] Uterus (Hysterectomy): Cervical Cancer
- [ ] NONE
- [ ] Other

_____
_____
_____

SKIN DISEASE HISTORY

Have you had any of the following?

- [ ] Acne
- [ ] Actinic Keratoses
- [ ] Asthma
- [ ] Basal Cell Skin Cancer
- [ ] Blistering Sunburns
- [ ] Dry Skin
- [ ] Eczema
- [ ] Flaking or Itchy Scalp
- [ ] Have fever/Allergies
- [ ] Melanoma
- [ ] Poison Ivy
- [ ] Precancerous Moles
- [ ] Psoriasis
- [ ] Sqaumous Cell Carcinoma of Skin
- [ ] NONE
- [ ] Other_____

Do you wear Sunscreen?

◯ Yes ◯ No

If yes, what SPF? _____

Do you tan in a tanning salon?

◯ Yes ◯ No

Do you have a family history of Melanoma? ◯ Yes ◯ No

- [ ] Mother
- [ ] Father
- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Aunt
- [ ] Nephew
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Granddaughter
- [ ] Grandson
- [ ] Other_____

SOCIAL HISTORY

Smoking Status (Please choose one):

- [ ] Current every day smoker
- [ ] Current someday smoker
- [ ] Former smoker
- [ ] Never smoker
- [ ] Unknown if ever smokes

Start smoking: mm/dd/yyyy: _____
Quit Smoking: mm/dd/yyy:_____
Number of Packs Per Day: _____
Total Years Smoking:_____

Alcohol Intake (please choose one):

- [ ] None
- [ ] 1 or less per day
- [ ] 1-2 per day
- [ ] 3 or more per day

Are you pregnant or currently breastfeeding?

- [ ] **YES**
- [ ] **NO**

Family History: (Please include only first degree relatives)

_____
_____
_____

ADVANCED DERMATOLOGY & SKIN CARE CENTRE

MINOR CONSENT BY PROXY FORM

I recognize that Advanced Dermatology & Skin Care Centre requires permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. When parents/legal guardians are not immediately available and advanced consent has not been provided, time must be taken to obtain permission and treatment may be delayed or even denied.

I also acknowledge that a specific treatment such as administration of a medication or procedure during a visit will require my verbal consent. Below, please note my parental authorization given so that my minor child may receive treatment at Advanced Dermatology & Skin Care Centre without his or her parent being present.

This authorization is effective on date signed and will become part of the patient record.

Patient's Name		Date of Birth	
Address			

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If not, you must state "NONE"

_____ (Initial) This certifies that the person listed below has my permission to authorize necessary medical care for my child. This authorization is in effect until revoked by me in writing. The following persons(s) have my permission to authorize medical care for my child and to sign any necessary general consents or acknowledgements on my behalf. The following person(s) will present valid ID for identification purposes and sign forms signifying my parental responsibility for payment.

Name		Name	
Address		Address	

UNACCOMPANIED MINOR CHILD CONSENT TO TREAT

_____ (Initial) My minor child, who is at least 14 years of age and named above, may present unaccompanied by an adult and receive treatment per this authorization. My child has permission to authorize my parental responsibility for payment if able to provide valid acceptable identification.

Parent/Legal Guardian Name	Signature	Date
CONTACT INFO		
Witness Name	Signature	Date

Mobile * 580 Providence Park Dr E * Mobile, AL 36695 * (251)631-3570 * Fax (251)631-3572

Daphne * 8573 County RD 64 * Daphne, AL 36526 * (251) 621-2244 * Fax (251) 621-7209