V6.14.17

AUGUSTA WEST DERMATOLOGY

3624 J. Dewey Gray Circle, Suite 250
Augusta, Ga 30909
Phone: (706) 922-7706 Fax: (706) 922-7999

Patient's Full Name_____ Birthdate_____ Age_____

Has this patient ever been known by any other name? (list)_____

Address: _____ City _____State_____ Zip: _____

Patient Soc. Security #: _____

Best Phone # (_____) _____ Can test results be left as a message on this phone? __Yes __No

Best E-Mail Address: _____@_____

Primary Care Physician: _____ Employer: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

Name of Insurance Company_____ Effective Date_____

Policy Number_____ Group Number_____

Policy Holder's Name_____ Date of Birth_____

Policy Holder Social Security Number: _____ Relationship to patient_____

Emergency Contact (other than relative already listed on this form):

Name _____ Relationship to patient_____

Address_____ Phone #_____

City_____ State _____ Zip_____

If patient is less than 18 years of age, please complete the following:

Patient Lives with: □ Both Parents □ Mother □ Father □ Other: _____

Father's Name: _____Soc. Security #_____ DOB_____

Employed by: _____ Work #_____Cell #_____

Address (if different from child) _____

City_____ State _____ Zip_____

Mother's Name: _____Soc. Security #_____ DOB_____

Employed by: _____ Work #_____Cell #_____

Address (if different from child) _____

City_____ State _____ Zip_____

RELEASE OF INFORMATION

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes any physician of Augusta West Dermatology to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for me or my dependents and that I am bound by this signature as though the undersigned had personally signed the particular claim.

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay and assign directly to Augusta West Dermatology all benefits, if any, payable to me for services as described on the attached forms. I further acknowledge that any insurance benefits received by Augusta West Dermatology will be credited to my account.

PAYMENT AGREEMENT

I give my consent for the examination and treatment of the above named patient including injections when indicated and properly authorized. If the patient is less than 18 years of age or incapable of caring for him/herself, I certify that I am a legal guardian or have been authorized by a legal guardian of the above named patient to consent for examination and treatment. I understand that it is my responsibility to provide Augusta West Dermatology with the current insurance information. I am aware that payment remains my personal responsibility regardless of insurance or other third party involvement (including court orders). I understand that if at any time a collection agency is employed to collect fees that I am responsible for the fees incurred up to 50% of the balance due. **I am aware of Augusta West Dermatology's financial policy. A copy is available for my review upon request if unable to view online at augustawestdermatology.com. All copays, coinsurance, and deductibles are to be paid at time of service.**

REFERENCE LABORATORY SERVICES & SPECIALTY REFERRALS

I understand that Augusta West Dermatology utilizes the service of an outside lab to perform some of the lab tests requested by its physician(s). I further understand that I will receive a separate bill from the reference laboratory for its services. I consent to Augusta West Dermatology providing demographic information as necessary for billing purposes. **I also recognize that I am responsible for going to a laboratory or specialty referral within my insurance provider's network.**

CANCELLATION OF APPOINTMENTS

I understand that I must give a 24-hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

NOTICE OF PRIVACY PRACTICES

I acknowledge by signing below that the Notice of Privacy Practices, Notice of Individual Rights are available to me and are posted for my review in the waiting room.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

MEDICATION REFILLS AND NON-URGENT PHONE CALLS

I understand that Dr. Miller is available by phone after hours for non-life threatening issues that need urgent medical attention (eg, bleeding from procedure site not responding to pressure). I understand that medication refills need to occur during business hours and will not be handled after hours. I understand that if my loved one or I have a medical condition that is life threatening, I will immediately call 911.

I have read the above information and agree to comply with the policies of Augusta West Dermatology:

_____

Date ***Signature of Patient or Parent (patient <18) or Legal Guardian*** Relationship to Patient

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Medical History

Name_____DOB_____ Date_____

Current tobacco user? __Yes __No

Medication Allergies: __Yes __ No Which ones?

_____

Allergies to adhesives __Yes __No

Pregnant/breastfeeding __Yes __No

Allergy to Lidocaine __Yes __No

Pacemaker __Yes __No

Defibrillator __Yes __No

Bleeding problems __Yes __No

Hepatitis B or C __Yes __No

HIV __Yes __No

Diabetes __Yes __No

On Blood thinner __Yes __No Which one?

_____

Thyroid disorder __Yes __No

Personal History of Skin Cancer: __Yes __No What type?

_____

Personal History of Cancer: __Yes __No What type? _____

Family history of skin cancer __ Yes __No _____

History of skin disease? __Yes __No What type? _____

History of keloids/excessive scars? __Yes __No

List any other diseases or conditions you have: _____

Occupation: _____

Hobbies: _____

How were you referred to the practice?_____

Current Medications (Dose NOT necessary):

Meds and ***allergies*** reviewed on: (for staff use): _____ --_____ -- _____ -- _____ -- _____ -- _____

Please fill out if interested in cosmetic products or procedures

Skin type: __dry __combination __oily

Interest in discussing:

___Sun protection
___Lip enhancement
___Anti-aging
___Wrinkle treatment
___Brown spots on hands
___Brown patches on face (Melasma)
___Rosacea with redness and flushing of cheeks
____Chemical Peels
____Botox/Xeomin
____Filler
____Laser for redness and enlarged capillaries on face
____Laser hair removal