Marietta Dermatology & Marietta Facial Plastics

PATIENT DEMOGRAPHICS

First Name____________________________ MI:______ Last Name:_________________________ Suffix:_____ Nickname:____________

Home Address: ____ City: _____________________State:_______ Zip:_________

Billing Address: ____ City: ____________________ State:_______ Zip:__________

DOB: _____/_____/_______ PHONE: Home #: (_____) ___________-______________ Cell #: (_____)_________-____________

PCP or Referring Physician: ____________________________________ Employer: ____

Soc. Sec. Number: __________-_______-___________ Gender: __________ Marital Status: _______________

Race: (Check all that apply)
- ☐ American Indian
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ White

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other

EMAIL ADDRESS ____

(By providing your email address you are consenting to receive Marietta Dermatology/Marietta Facial Plastics updates or offers from which you can unsubscribe at any time as well as registering for Patient Online Portal.)

RESPONSIBLE PARTY | GUARDIAN INFORMATION

If same as above check here: ☐

Person Responsible for Account:____ Relationship:__________________________

Billing Address:____ City: _____________________ State:_______ Zip:_________

PHONE Home #: (_____)________-___________ Cell #: (_____)_______-___________Email: __________________________________

INSURANCE POLICY INFORMATION

1st Insurance:__________________________________ Contract #:_________________________________ Group #: _________________

Claims Address:____ Phone Number:____________________

Policy Holder: Name: _____________________ DOB: ____/____/____ SSN: ___________Relationship To Patient ___________________

If same as patient check here: ☐

2nd Insurance:__________________________________ Contract #:_________________________________ Group #:________________

Claims Address:____ Phone Number:__________________

Policy Holder: Name: _____________________ DOB: ____/____/____ SSN: ___________Relationship To Patient ___________________

3rd Insurance:__________________________________ Contract #:_________________________________ Group #:_________________

Claims Address:____ Phone Number:____________________

Policy Holder: Name: _____________________ DOB: ____/____/____ SSN: ___________Relationship To Patient ___________________

HOW DID YOU HEAR ABOUT US? ____

Marietta Dermatology & Marietta Facial Plastics

Patient name:____________________ DOB:______________________

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:

Name ________________________________ Phone (_______) ________ - __________ Relationship to Patient_________________________

ADDITIONAL CONTACT INFORMATION

In the event we need to contact you for **clerical purposes (i.e. appointments, billing)**, what are your preferred methods of communication?

- ☐ Phone/ Answering Machine/ Voicemail
- ☐ Email
- ☐ Text Message

In the event we need to contact you for **clinical purposes (i.e. lab/ biopsy results, relevant medical information)**, what are your preferred methods of communication?

- ☐ Phone/ Answering Machine/ Voicemail
- ☐ US Mail
- ☐ Email / Patient Portal -*A system in which patients access personal health information electronically*

May we discuss **appointment confirmation, lab/biopsy results, or any relevant medical informatio**n with family members or friends? **☐Y ☐N**
If yes, please list below: If a person is not listed by name, we cannot speak to them regarding your care at MDA.

____

First Name Last Name Relationship Phone Number

____

First Name Last Name Relationship Phone Number

Marietta Dermatology & Marietta Facial Plastics

Patient name:____________________ DOB:______________________

MEDICAL HISTORY

	Self	Father	Mother	Sibling	Child	Other
Acne\Rosacea	☐	☐	☐	☐	☐	☐
Psoriasis\Eczema	☐	☐	☐	☐	☐	☐
Overgrowth of Hair	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐
Cancer-Other_____	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma/Hay Fever	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Peptic Ulcers	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐

Do you have any sexually transmitted diseases such as HPV, HIV Herpes or other? ___________

Other Health Issues:____

Please list any major surgeries you have had in the past:

____

____

____

SMOKING STATUS

- ☐ Never Smoked
- ☐ Current every day smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Former smoker

ALCOHOL DRINKING STATUS

- ☐ Never
- ☐ Current every day drinker **How much per day?____**
- ☐ Social Drinker
- ☐ Occasional

If you have ever smoked, what year did you begin smoking? _____________
If you are a former smoker, what year did you quit smoking? _____________

SUNSCREEN PROTECTION
Do you use sunscreen? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

ALLERGIES

Do you have any known DRUG allergies?

- ☐ Lidocaine
- ☐ Xylocaine
- ☐ Novacaine
- ☐ Latex
- ☐ Other_____________

Please list current medications:

☐ See attached list

____

____

____

____

PHARMACY

Name: ____ Street/City: ____

PHONE #: (________) _________-_______________

Marietta Dermatology & Marietta Facial Plastics

Patient name:____________________ DOB:______________________

PATIENT POLICIES AND NOTICES

Guarantee of Payment
In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Marietta Dermatology, insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees, and court costs if such be necessary, waiving now and forever the right to accept insurance assignment as a guarantee of full payment.
_________ (PLEASE INITIAL)

In-House Dermatopathology Lab
I understand that Marietta Dermatology has an in house pathology lab that my biopsies will be sent to and that my biopsies will be read by a certified Dermatopathologist. I understand that I may receive additional billing from Marietta Dermatology for portions of my deductible not yet met, coinsurance and in some cases, an additional co-pay.
_________ (PLEASE INITIAL)

Marietta Dermatology Clinical Research
I understand that Marietta Dermatology has my best interests in mind and from time to time their Clinical Research Department may search my medical records and contact me in the event that I may be eligible to participate in a no cost Clinical Trial that could benefit me and other patients.
_________ (PLEASE INITIAL)

Assignment of Insurance Benefits and Release of Information
My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to Marietta Dermatology. Furthermore, my signature below authorizes Marietta Dermatology to release to my insurance company medical information regarding my treatment for the purposes of determining eligibility for and payment of charges for services rendered in connection with care.
_________ (PLEASE INITIAL)

Health Insurance Portability and Accountability Act (HIPAA)
I consent to the use or disclosure of my protected health information (PHI) by Marietta Dermatology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.
________ (PLEASE INITIAL)

I have received a copy of the Marietta Dermatology Notice of Privacy Practices. The notice describes the types of uses and disclosures of my PHI that will occur in my treatment, payment for my health care bills or in the performance of health care operations of Marietta Dermatology.
________ (PLEASE INITIAL)

Marietta Dermatology reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.
_______(PLEASE INITIAL)

ePrescribing
Marietta Dermatology has implemented ePrescribing. ePrescribing sends your prescriptions over the internet to your pharmacy; keeping your personal information protected. ePrescribing also lets your doctor see important information- like drug interactions and your prescription history. I authorize, with the signature below, that Marietta Dermatology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes through ePrescribing software.
_______ (PLEASE INITIAL)

Patient or Responsible Party Signature: ____ Date _______/_______/_________