Georgia Dermatology Center

PATIENT REGISTRATION

Name: _____ Date of Birth: _____ Sex: _____

Guarantor Name (if patient is a minor): _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone: _____ Mobile Phone: _____

(Primary Phone will be used for Appointment Reminder Calls)

SS#: _____ Marital Status: _____ Employer: _____

Race: _____ Height: _____ Weight: _____ Language: _____

Ethnicity: (circle one) Hispanic /Latino OR Non-Hispanic/Non-Latino

E-Mail: _____ Referring Doctor: _____

Pharmacy Name & Location: _____ Emergency contact: _____

Relationship: _____ Phone #: _____

Insurance company: _____ Policy Holders Name: _____

SS# _____ Date of Birth: _____ Relationship: _____

How did you hear about our practice? _____

MEDICAL INFORMATION

Reason for today's visit: _____ Do you have any known **DRUG ALLERGIES**? _____

Do you have HIV? ❑ Yes ❑ No Do you have a history of HEPATITIS? ❑ Yes ❑ No If so, what type: ____ A ____ B ____ C

Do you have a personal history of skin cancer? ❑ Yes ❑ No Do you have a personal history of malignant melanoma? ❑ Yes ❑ No

Do you have a family history of malignant melanoma? ❑ Yes ❑ No (please circle) mom dad brother sister or child

Do you drink alcohol? ❑ Yes ❑ No Do you smoke? ❑ Yes ❑ No Do you have a pacemaker? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No

Flu Vaccine? ❑ Yes ❑ No (month/year taken) _____

Pneumonia Vaccine? ❑ Yes ❑ No (month/year taken) _____

Please initial the appropriate categories, if you agree that this organization may disclose the following information contained to your medical/billing records: HIV / AIDS: _____ Mental Health: _____ Substance abuse: _____ Sexually Transmitted Disease: _____

Pregnancy Information: _____

Please list, attach, give us a copy of all medications and reason you are taking them, including non-prescription, hormone pills, and aspirin: _____

_____

_____

Do we have your permission to:

Leave a message on your answering machine at home? ❑ Yes ❑ No OR Cell Phone ❑ Yes ❑ No

Leave a message at your place of employment? ❑ Yes ❑ No

Discuss your medical condition with any member of your household? ❑ Yes ❑ No

If yes, whom: _____ Relationship: _____

All Patients Please Sign

- I authorize the release of any medical information needed to process Medicare and/or other insurance.
- I authorize Georgia Dermatology Center to treat the above named patient (including minors) as necessary including biopsies, surgeries and prescriptions.
- I authorize the release or acquisition of any medical information to/from any physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care. I have read the HIPPA privacy policy of Georgia Dermatology Center.

Signature of Patient/Guardian: _____ Date: _____