

Garrott Dermatology

Patient Information

Patient Name: _____

Date: ____/____/____

Reason for today's visit: _____

Past Medical History: (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> GERD (Acid Reflux) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) |
| <input type="checkbox"/> Benign Prostatic Hypertrophy
(Enlarged Prostate) | <input type="checkbox"/> Hypertension (High Blood Pressure) |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Thyroid Disease: High or Low (Circle One) |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Other: _____ |

Past Surgical History: (please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Liver Removal |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Liver Transplant |
| <input type="checkbox"/> Breast Biopsy (L, R, or Both) | <input type="checkbox"/> Liver Shunt |
| <input type="checkbox"/> Lump Removal (L, R, or Both) | <input type="checkbox"/> Ovaries Removed : _____ (Reason) |
| <input type="checkbox"/> Breast Removal (L, R, or Both) | <input type="checkbox"/> Ovaries: Tubal Ligation |
| <input type="checkbox"/> Colon: Colon Cancer Resection | <input type="checkbox"/> Pancreas Removal |
| <input type="checkbox"/> Colon: Diverticulitis | <input type="checkbox"/> Prostate: Biopsy |
| <input type="checkbox"/> Colon: Inflammatory Bowel Disease | <input type="checkbox"/> Prostate Removal for Cancer |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Prostate: TURP |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Rectum: APR |
| <input type="checkbox"/> Heart: Valve Replacement
(Mechanical or Biological) | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Skin: Basal Cell Carcinoma |
| <input type="checkbox"/> Heart: Transplant | <input type="checkbox"/> Skin: Biopsy |
| <input type="checkbox"/> Heart: PTCA (Angioplasty) | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Joint Replacement: Knee (L, R, or Both) | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Joint Replacement: Hip (L, R, or Both) | <input type="checkbox"/> Spleen Removal |
| <input type="checkbox"/> Kidney: Biopsy | <input type="checkbox"/> Testicles Removal |
| <input type="checkbox"/> Kidney: Stone Removal | <input type="checkbox"/> Uterus Removal: _____ (Reason) |
| <input type="checkbox"/> Kidney Removal (L, R, or Both) | <input type="checkbox"/> Other: _____ |

Skin Disease History:

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Lesions |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaky or Itchy Scalp | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Basal Cell Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Psoriasis/Psoriatic Arthritis |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Other: _____ |

Do you wear sunscreen? Yes No
If yes, what SPF? ____

Do you tan in a tanning salon? Yes No

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Patient Information

Do you have a family history of Melanoma? Yes No

If yes, what relative(s)? _____

Any other family history: _____

Medications: (Please enter all current medications including prescriptions, over-the-counter meds., vitamins, and herbals; the current dosage & frequency are also needed for each.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Social History: (Please check all that apply)

Cigarette Smoking:

- | | |
|--|---|
| <input type="checkbox"/> Never smoked | <input type="checkbox"/> Smokes less than daily |
| <input type="checkbox"/> Quit: former smoker | <input type="checkbox"/> Smokes daily |

Illicit Drug Use:

- Drug Use
 IV Drug Use

Alcohol Use:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol: none | <input type="checkbox"/> Alcohol: 1-2 drinks per day |
| <input type="checkbox"/> Alcohol: less than 1 drink per day | <input type="checkbox"/> Alcohol: 3 or more drinks per day |

Safety:

- I feel safe at home.
 I do not feel safe at home.

Do you have a pacemaker? Yes No

Do you have a defibrillator? Yes No

Do you bleed easily? Yes No

(WOMEN) Are you pregnant or planning pregnancy? Yes No

Do you have problems with healing? Yes No

Do you develop keloids (scars)? Yes No

Do you develop skin reactions to: Latex Lidocaine Adhesive?

Language: English Spanish Vietnamese Other: _____

Race: Caucasian Black/African American Asian Hispanic Native American

Other: _____

Pharmacy: _____ City: _____

Signed by Patient/Patient's Representative: _____

Date signed: ____/____/____

**Garrott Dermatology
Patient Information**

Name: _____ Jr. ____ Sr. ____
First Middle Last

Street Address: _____ City: _____ Zip: _____ Phone: (____) _____

Social Security #: _____ Age: ____ Sex: _____ DOB _____ Marital Status: _____

Patient's Employer: _____ Patient's Occupation: _____

Employer's Address: _____ Employer's Phone: (____) _____

Full Time? ___ Part Time? ___ Retired? ___ Student? ___ Personal Email: _____

Spouse's name: _____ Spouse's SSN: _____ Spouse's DOB: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Employer's Address: _____ Employer's Phone: (____) _____

Responsible Party: _____ Address: _____

Social Security #: _____ DOB: _____ Relationship to Patient: _____

Employer: _____ Address: _____ Phone #: (____) _____

Nearest Relative (not living with you): _____ Phone #: (____) _____

#1 Insurance Co. Name: _____ Policyholder's Name/SSN: _____ DOB: _____

#2 Insurance Co. Name: _____ Policyholder's Name/SSN: _____ DOB: _____

PLEASE PRESENT PHOTO ID & INSURANCE CARD(S) TO THE RECEPTIONIST TO MAKE COPIES

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICES RENDERED, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE.** It is your responsibility to pay any balance not paid by your insurance. In the event the account is turned over for collection, the collection and/or legal fees, including attorney fees, shall be your responsibility. Your signature below indicates that you understand and accept this herein and authorize payment of medical benefits to the Doctor when assigned claim is filed.

Signature: _____ Date: _____

Attention: Please be advised that Garrott Dermatology Clinic uses Dermlab Dermatopathology (located in Alabama) for skin biopsies and cultures. If your insurance requires specimens to go to Ocean Springs Hospital please let your provider know at time of service. All services performed by the hospital or lab are billed separately, and it is the patient's responsibility for payment.

In order for us to reach you regarding appointments or results, do we have your permission to leave a message on your:

Voicemail? ___ Place of employment? ___ Email? ___ Fax? ___ if yes, provide fax #: _____

Do we have your permission to speak with anyone in your household regarding your medical condition? ___ Yes ___ No

Yes, whom? _____ Relationship _____ Phone _____

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Patient Information

PATIENT/PATIENT'S REPRESENTATIVE PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Thomas C. Garrott, M.D.
Fellow of the American Board of Dermatology
Alan Crawford, PA-C
24 Marks Road
Ocean Springs, MS 39564
Tel: (228)872-8873 Fax: (228)872-8876

Right to Revoke: You have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving to you your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is being signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____