

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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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:

Never smoked

Smokes less than daily

Quit: former smoker

Smokes daily

Illicit Drug Use:

Drug Use

IV Drug Use

Alcohol Use:

Alcohol: none

Alcohol: 1-2 drinks per day

Alcohol: less than 1 drink per day

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 Name: _____ City: _____ State: _____

Signed by Patient/Patient's Representative: _____

Date: ___/___/___

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PATIENT INFORMATION:

Name: _____ Jr. ____ Sr. ____
Social Security#: _____ DOB: _____ Sex: _____ Marital Status: _____
Mailing Address: _____ City: _____ State _____ Zip: _____
Cell Phone: (____) _____ Home Phone: (____) _____ Email: _____
Employer: _____ Occupation: _____ Work Phone: (____) _____
Primary Care Physician: _____ Primary Care Phone: (____) _____

RESPONSIBLE PARTY: (IF NOT PATIENT)

****ONLY** complete this section if patient is UNDER the age of 18 or if someone other than the patient is legally responsible.
****Responsible party MUST BE PRESENT** at the time of appointment and **MUST PROVIDE PICTURE ID.**

Responsible Party's Name: _____ Jr. ____ Sr. ____
Social Security #: _____ DOB: _____ Relationship to patient: _____
Mailing Address: _____ City: _____ State _____ Zip: _____
Employer: _____ Occupation: _____ Work Phone: (____) _____

INSURANCE INFORMATION:

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

Primary Insurance: _____ **Secondary Insurance:** _____
Policyholder's Name: _____ Policyholder's Name: _____
Policyholder's DOB: _____ Policyholder's DOB: _____

PERMISSION TO GIVE MEDICAL INFORMATION:

****If we have permission*** to leave a voicemail regarding results, please provide your phone number by each of the following:

*Cell Phone: (____) _____ *Home Phone: (____) _____

I hereby authorize the physicians and staff of Garrott Dermatology to give information concerning my health and well-being to the person(s) listed below. Including appointment times, test/lab results, prescription refills, procedures, and any other information regarding my health:

Name: _____ Relationship: _____ Phone: (____) _____
Name: _____ Relationship: _____ Phone: (____) _____

Signature of Patient (or responsible party): _____ **Date:** _____

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Patient Information

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

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 ALL MAJOR CREDIT CARDS (INCLUDING CARE CREDIT) 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.

***** Attention:** Please be advised that Garrott Dermatology Clinic uses DermLab Dermatopathology (located in Alabama) for skin **biopsies and cultures**. If your insurance requires specimens for biopsies or cultures 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. *******

SIGNATURE: _____ **DATE:** _____

Notice of Privacy Practices:

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.

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.

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:** _____