

Please complete the following medical history form

Name _____ Date _____

Age ____ Sex ____ Referring Doctor _____

Reason for today's visit: History of today's problem(s):

Skin areas involved: _____ How long has the problem been present? _____

Was a biopsy done? No Yes biopsy done by referring MD Other
Was there any previous treatment? No Yes If yes, what was done and when?

Check all that apply regarding today's problem: Change in: Size Color Bleeding Elevation
 Hardness

Please list all medications: (Include vitamins, herbs, supplements) _____

Medication: **ALLERGIES:** None List: _____

Check *ALL* that apply regarding your overall health *and add any other medical problems:*

CARDIOVASCULAR

- normal
- artificial heart valve
- pacemaker
- high blood pressure
- heart attack when?
- high cholesterol

- bypass or other surgery
- Mitral valve prolapse
- other heart problem

GASTROINTESTINAL

- normal
- stomach ulcer
- colitis
- irritable bowel syndrome

NEUROLOGICAL

- normal
- stroke
- seizure disorder
- Alzheimer's

**PSYCHIATRIC
MUSCULOSKELETAL**

- normal
- depression
- anxiety disorder
- other:

BLOOD / LYMPH

- normal
- anemia
- enlarged lymph glands
- bleeding problems

RESPIRATORY

- normal
- emphysema

ENDOCRINE

- normal
- diabetes
- thyroid problem

SKIN

- normal
- keloids
- poor/slow healing

GENERAL

- normal
- fever weight loss

INFECTIONS

- none
- hepatitis
- HIV or AIDS
- TB (tuberculosis)

- normal
- arthritis
- artificial joint
- fibromyalgia

HEAD / NECK

- normal
- hearing aid
- glaucoma
- plastic surgery

OTHER MEDICAL PROBLEMS: _____

Previous skin cancer? _____

MAJOR ILLNESS OR HOSPITALIZATIONS: None List: _____

FAMILY HISTORY: melanoma other skin cancer (basal cell or squamous cell)
 bleeding problems other major medical problems:

Occupation: _____ Marital Status: S M D W

- Do you wear: dentures glasses contact lenses
- Smoking: no former yes; how many packs/day? _____
- Alcohol: no social drinking only
- Alcohol or drug problems/addictions: no describe: _____



Dr. Juan A. Mujica
Dr. Neville G. Pereyo
Dr. Maria R. Pico
Grace Bogert, PA-C
Matthew Brunner, PA-C

Martha Sikes, PA-C
Christopher Golden, PA-C
Dr. Mark Baucom
Dr. David Pharis

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

1. With my consent, DERMATOLOGY AND SKIN SURGERY CENTER may use the following methods to communicate with me.
Call to my home or other designated location and leave a message on voicemail or in person, **mail** to my home or other designated location, or **email** to my home or other designated location.
2. I also understand and consent that my personal health information may be disclosed to other appropriate entities, such as (but not limited to) my insurance company (ies), other physicians or health care providers and others as indicated in the Notice of Privacy Practices.
3. I have the right to request that DERMATOLOGY AND SKIN SURGERY CENTER restricts how it uses or discloses my personal health information. I request the following restrictions(s):

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. The above restrictions ARE, ARE NOT agreed to by DERMATOLOGY AND SKIN SURGERY CENTER.

Signed: _____ Position/Title: _____ Date: _____

4. If I do not sign this consent, DERMATOLOGY AND SKIN SURGERY CENTER may decline to provide treatment to me. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

By signing this form I am consenting to DERMATOLOGY AND SKIN SURGERY CENTER Use and disclose of my personal health Information (PHI) to carry out treatment, Payment, and operations (TPO).

I also authorize assignment of insurance benefits to DERMATOLOGY AND SKIN SURGERY CENTER.

Signature of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Patient's or Guardian's Printed Name

Date



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NON-COVERED SERVICES

I understand that the following procedures / services are usually considered as **non-covered services**. If I request medical or surgical treatment for these diagnoses, I will be responsible for the fees.

- Acrochordons (Skin Tags)
- Alopecia (Hair Loss)
- Benign Nevi (Moles)
- Hair Removal (Waxing, Electrolysis, Laser)
- Lentigo (Liver Spots, Age Spots)
- Keloid (Injections/Surgery)
- Dermabrasion
- Scar Revision/Acne Scarring
- Seborrheic Keratosis
- Facials
- Spider Veins (Leg and Facial)
- Tattoo Removal
- Dilated Blood Vessels
- Liposuction
- Laser Surgery/Consult
- Injections (Cortisone)
- Chemical Peels
- Milia (Cysts)
- Ear Piercing
- Male Pattern Baldness
- Split Earlobe Repair
- Sebaceous Hyperplasia
- Wrinkles

PLEASE READ – OUR FINANCIAL POLICY

- All cosmetic surgeries/procedures are to be paid for in full, prior to procedure being done.
- All co-payments will be collected upon completion of the Patient Information Sheet or at sign-in prior to seeing the physician.
- If we are not a provider for your insurance, or if you have not met your deductible, or are ineligible for benefits, FULL PAYMENT WILL BE COLLECTED TODAY.
- Deposits for procedures are non-refundable.
- All billed balances must be paid within 30 days of 1st billed date, after which they are subject to collection efforts.
- All returned checks are subject to a \$30.00 returned check fee.
- Tissue specimen will be sent to a Board Certified Dermatopathologist, who will bill a separate fee.

Patient signature (or guardian) _____

Date _____



DERMATOLOGY AND SKIN SURGERY CENTER
210 Village Center Parkway
Stockbridge, GA 30281 Phone: 770-474-5952

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Patient Information Please Print

Today's Date ____/____/____

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____

Address No PO Boxes _____

City _____ State and Zip _____

() - () - () -

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth MM / DD / YY _____ Current Age _____

Sex MALE OR FEMALE _____ Martial Status _____

Patient or Responsible Party (If different from patient)

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State and Zip _____

() - () - () -

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth MM / DD / YY _____

Sex MALE OR FEMALE _____

Relationship of patient to the Insured _____

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name	_____	Secondary Insurance Name	_____
Name of Insured	_____	Name of Insured	_____
Insured's ID #	_____	Insured's ID #	_____
Group #	_____	Group #	_____
Pharmacy of Choice	_____	Phone	_____
In case of Emergency, who should be notified?	_____	Phone	_____
Referred by:	_____		
Primary Care Physician:	_____		

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Today's Date ___/___/___

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductibles, non-covered services and copayments.

In the event you must cancel a surgical or cosmetic appointment, we must be notified at least 48 hours prior to your appointment time. If not, you will be charged a \$50 cancellation fee for a surgical appointment and your cosmetic deposit will be forfeited. All unpaid balances over 90 days will be charged a \$2.00 per month finance charge. After 120 days of non-payment, an additional \$10.00 charge will be added and your account will be forwarded to an outside collection agency.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Today's Date ___/___/___

Copy of insurance card (both sides) attached.

Updated by:
