SOUTHEASTERN Dermatology

Patient Intake Form

Patient Name: _____

Date of Birth: _____ Gender: _____

Parent/Legal Guardian if minor: _____

Address:_____

_____

Home Phone:_____Mobile Number:_____

Work number: _____ Email Address: _____

Emergency Contact:_____

Medical Contact Information:

Referring Physician:_____Phone Number:_____

Primary Care Physician:_____Phone Number:_____

Preferred Pharmacy:_____Phone Number:_____

Medical History

Current Medications: (including over the counter)

_____

_____

_____

Drug Allergies: _____

Do you have a family history of melanoma or other skin cancers? ____ Yes ____ No

If yes, which relative? What type of skin cancer?

_____

Smoking Status: ___Current Smoker ____Former Smoker _____Never Smoker

Do you drink alcohol: ____ No ___Yes, _____

Do you wear sunscreen daily: ____No ___Yes What SPF? _____

SOUTHEASTERN Dermatology

PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name: _____ Patient DOB: _____

A. FAMILY AND FRIENDS: It is the office policy of Southeastern Dermatology not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

B. ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner. (check all that apply)

Home Phone _____
_____ Okay to leave message with details
_____ Leave a call back number only

Cell Phone _____
_____ Okay to leave message with details
_____ Leave a call back number only

Work Telephone _____
_____ Okay to leave message with details
_____ Leave a call back number only

Written Communication
_____ Okay to mail to home address

X_____ _____ _____

Patient or Representative Signature Relationship to patient Date

SOUTHEASTERN
Dermatology

Financial Policy

Patient Name: _____DOB: _____

Southeastern Dermatology is committed to serving our patients with professionalism and care and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits. As a courtesy, and if we are contracted with your insurance company, Southeastern Dermatology will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

If you do not have insurance coverage or fail to provide proof of insurance, you will be considered a self-pay patient and will be responsible for any and all fees incurred for your visit.

In order to provide timely appointments without excessive wait time, we ask that patients arrive to their appointments on time. Please be advised that we reserve the right to reschedule an appointment if a patient is more than 15 minutes late.

If you are unable to make your appointment, Southeastern Dermatology requires a 24-hour notice prior to your appointment for cancellations. If you do not cancel your appointment within this time period, you are subject to a $35 cancellation/no show fee. This fee will be the responsibility of the patient and is not covered by insurance. An excessive amount of missed appointments could result in being discharged from our practice.

I have read and understand the financial policy statement. I agree to make prompt payment in full to Southeastern Dermatology at the time of my visit, or when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. I also give consent for Southeastern Dermatology to release any medical information necessary to process my insurance claims. Any unpaid balances will result in collection actions.

FINANCIAL POLICIES ACKNOWLEDGEMENT

I acknowledge that I have received, read and agree to the stated Office Policies of Southeastern Dermatology.

Signature: _____Date: _____
Legal Guardian (If minor)_____

SOUTHEASTERN Dermatology

Office Policies

Consent to treatment: I understand and herby give consent that during my visit today, or on future visits it may be necessary to have a skin biopsy, cryotherapy (Liquid Nitrogen)or other minor procedures for the treatment of my skin conditions. I understand that there may be potential risks such as scarring, bleeding, and infection.

If you require emergency medical services please call 911 immediately. If this is an urgent medical need and you need to speak with a provider after our normal business hours, please call (850)422-3376. Your call will be returned promptly.

It is customary to have photos taken to help in the guidance and care of your medical needs. These photos are for in office use only. If photos are needed for any other purpose, additional permission will be requested.

A parent or guardian must be present with a patient under the age of 18 for the first visit and any subsequent visit in which a procedure is performed. The parent/guardian grants permission to Southeastern Dermatology to see the minor without their presence for standard medical office visits. This authorization is valid until revoked in writing. I have legal right to select and authorize health care services for this minor child.

Written Acknowledgement Form: I am a patient, parent or legal guardian of _____ at Southeastern Dermatology. I hereby acknowledge receipt of Southeastern Dermatology's Notice of Privacy Practices.

OFFICE POLICIES ACKNOWLEDGEMENT

I acknowledge that I have received, read and agree to the stated Office Policies of Southeastern Dermatology.

Patient Name: _____DOB:_____
Legal Guardian (if minor) _____
Signature: _____Date: _____

SOUTHEASTERN Dermatology

Cosmetic Questionnaire

Patient Name: _____DOB: _____

Do you have any concerns with fine-lines, wrinkles, or volume loss (cheeks/Lips)? __Yes___No

Do you have any concerns with skin laxity, color variation, or texture? ___Yes____No

Do you have sun spots, spider veins, or any unwanted hair you would be interested in treating?__Yes___No

Would you be interested in scheduling a cosmetic consultation? __Yes___No

Would you like information about any of the following:

____Botox

____Juvéderm/Fillers

____Laser hair removal

____Spider Vein Treatment

____Rosacea/Facial redness

____ Skin Care Products

___ Facials

___ Chemical Peels

___ Microderm Abrasion

___Microneedling

___Dermaplaning

____Cosmetic mole or Skin tag Removal

Comments: _____
_____
_____
_____
_____