DERMATOLOGY MEDICAL ASSOCIATES

NAME:_____NICKNAME:_____DOB:_____

MAILING ADDRESS: _____ CITY/STATE: _____ ZIP:_____

HOME PHONE: _____ CELL PHONE: _____WORK PHONE: _____

( ) MALE ( ) FEMALE MARITAL STATUS:_____SS#_____

EMPLOYER: _____ OCCUPATION:_____

RESPONSIBLE PARTY:_____ RELATIONSHIP:_____

DOB: _____ SS# _____ PHONE# _____

MAILING ADDRESS: _____

EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE:_____

RELATIONSHIP: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I HEREBY AUTHORIZE DERMATOLOGY MEDICAL ASSOC TO RELEASE ANY INFORMATION NECESSARY FOR MY COURSE OF TREATMENT TO:

( ) SPOUSE _____ ✓ ANY/ALL INFORMATION TO BE SHARED INITIAL (_____)

( ) OTHER PERSON _____

( ) LEAVE A MESSAGE ON MY ANSWERING MACHINE/VOICEMAIL: (✓) YES ( ) NO

MEDICAL CONSENT TO THE EXAMINATION, TREATMENT AND PROCEDURES WHICH MAY BE PERFORMED DURING THE OFFICE VISIT INCLUDING EMERGENCY TREATMENT CONSIDERED NECESSARY BY THE PHYSICIAN. IF AN INVASIVE PROCEDURE IS NECESSARY A SPECIFIC CONSENT FORM WILL BE DISCUSSED WITH ME AT THAT TIME.

FINANCIAL POLICY AND CONSENT: PAYMENT OF DEDUCTIBLES AND COPAYMENTS IS EXPECTED AT THE TIME OF SERVICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE BALANCE OWED AFTER MY INSURANCE CARRIER(S) HAVE BEEN BILLED. I AGREE TO PAY FOR ALL THE SERVICES RENDERED TO ME. I CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION TO INSURANCE CARRIERS OR ORGANIZATION RESPONSIBLE FOR PAYMENT OF MY BILLS FOR SERVICE RENDERED.

SIGNATURE: _____ DATE: _____

1363 7TH AVENUE EAST HENDERSONVILLE, NC 28792 P)828-698-5757 F)828-698-5799

DERMATOLOGY MEDICAL ASSOCIATES

PATIENT NAME: _____ DOB: _____

NATURE OF PROBLEM: _____

PAST HISTORY:

1. MAJOR ILLNESS: _____

   _____

2. MAJOR OPERATIONS: _____

   _____

3. DO YOU HAVE:

   DIABETES_____ HEART DISEASE_____ HIGH BLOOD PRESSURE_____

   PACEMAKER _____ ARTIFICIAL JOINTS_____ ARTHRITIS_____

4. ALLERGIES TO MEDICATION, LATEX, FOOD OR ENVIRONMENTAL SURROUNDINGS_____
5. HAVE YOU EVER BEEN TREATED FOR SKIN CANCER?_____

   IF YES WHICH TYPE?_____

6. IMMEDIATE FAMILY HISTORY OF SKIN CANCER? _____
   IF YES EXPLAIN:_____
7. DO YOU SMOKE? _____
8. HAVE YOU RECEIVED THE PNEUMONIA VACCINE? _____
9. MEDICATIONS YOU CURRENTLY TAKE AND DOSAGE: _____

   _____

   _____

10. IF PATIENT IS A FEMALE, ARE YOU PREGNANT? _____ WEEKS? _____
11. WHICH PHARMACY DO YOU USE? _____
12. WHO IS YOUR PRIMARY PHYSICIAN? _____

HOW DID YOU HEAR ABOUT US? _____

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DERMATOLOGY MEDICAL ASSOCIATES

FORM OF WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF DERMATOLOGY MEDICAL ASSOCIATES

NOTICE OF PATIENT PRIVACY PRACTICES

BY SIGNING THIS WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF:

DERMATOLOGY MEDICAL ASSOCIATES NOTICE OF PATIENT PRIVACY PRACTICES (ACKNOWLEDGEMENT), I HEREBY EXPRESSLEY ACKNOWLEDGE MY RECEIPT OF DERMATOLOGY MEDICAL ASSOCIATES OF PRIVACY PRACTICES

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

_____

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE DATE

ACKNOWLEDGEMENT NOT OBTAINED BECAUSE:

_____ PATIENT OR LEGAL REPRESENTATIVE, DECLINED NOTICE OF PATIENT PRIVACY PRACTICES

_____ OTHER, BRIEFLY DESCRIBE: _____