SIA
DERMATOLOGY

Patient Information

Patient Name _____ Today's Date _____
Mailing Address _____
City _____ State _____ Zip _____
DOB _____ Age _____ Sex _____ Marital Status ☐ M ☐ S ☐ D ☐ W
Primary Phone _____ Cell/Home Secondary Phone _____ Cell/Home
Employer _____ Work Phone _____
May we contact you at work? Yes / No Do you wish phone calls to be confidential? Yes / No
Email for patient portal access _____
SSN _____ How did you hear about our practice? _____
Referring Physician (if applicable) _____
Primary Care Physician _____

Emergency Contact Information

Contact Name _____ Relationship to Patient _____
Contact Number _____ Alternate number _____

Insurance Information

Primary Insurance

Insurance Company _____ Policy ID Number _____
Cardholder's Name _____ Relationship to Patient _____
Cardholder's DOB _____ Cardholder's SSN _____
Cardholder's Employer _____

Secondary Insurance

Insurance Company _____ Policy ID Number _____
Cardholder's Name _____ Relationship to Patient _____
Cardholder's DOB _____ Cardholder's SSN _____
Cardholder's Employer _____

I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including those amounts not paid by my insurance company. Also, I agree that to my knowledge the above information is the most accurate and up to date. I authorize the release of this information as well as the release of medical records, if necessary, for payment by my insurance carrier. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collection, any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws.

Please note, there may be additional costs from outside laboratories. Biopsies, cultures, and other medical specimens will be sent to an outside lab. It is the patient's responsibility to contact their insurance carrier with inquiries regarding network coverage for these facilities. Information on these facilities will gladly be supplied to the patient at their request.

Responsible Party Signature _____ **Date** _____

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No Show Policy

Patient Name _____ Date of Birth _____

FOR ALL PATIENTS
In order to deliver quality care in a timely manner, we ask that you please provide a 24-hour notice for all cancellations.

A $25 “no show” fee will be charged to your account if a 24-hour notice is not provided. We understand that situations may arise that prevent you from making your appointment, but repeated occurrences may be cause for dismissal from our care.

In signing this form you are acknowledging that you have read and understand this policy. If you have questions regarding this, please contact our office. Thank you.

_____ _____
Patient/Parent/Guardian Signature Date

_____
Patient/Parent/Guardian Name Printed

1733 West Main Street Suite 500 Dothan AL 36301
334.699.7546

SIA
DERMATOLOGY

Authorization for Verbal Release of Protected Health Information

STANDARD DISCLOSURE

I authorize SIA Dermatology to discuss my medical history, diagnosis, treatment, prognosis, and financial, insurance and billing information with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS-related illness, mental health and drug, alcohol or chemical abuse, as well as, confirmation of any appointment for me to be seen in the office, hospital or other physicians office.

☐ Spouse _____

☐ Children _____

☐ Parent(s) _____

☐ Other _____

☐ NO INFORMATION
I do not authorize release of any verbal information concerning my treatment. I understand that this includes confirmation of appointment dates, times, location and any billing or financial information.

I consent and authorize the release of any test results to be left on my voicemail at:

☐ Home ☐ Cell ☐ Work number ☐ Other _____

This authorization will expire at the end of my treatment with SIA Dermatology unless I revoke the consent prior to that time.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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SIA DERMATOLOGY

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of SIA Dermatology's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient or Legal Representative

Relationship to Patient *(if applicable)*

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

ePRESCRIBING CONSENT

ePrescribing is a federally mandated initiative that requires physicians to send prescriptions over the internet to your pharmacy using secure technology to protect the privacy of your personal information. I understand that I have the right to refuse to sign this consent. I hereby consent to ePrescribing.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient or Legal Representative

Relationship to Patient *(if applicable)*

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of **Privacy Practices** and **ePrescribing Consent** from (patient name) ____________________________________ on (date) ______________________ but this could not be obtained because:

- ☐ Patient/Representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgment at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgment (Specify)

____

- ☐ Other (Specify)

____

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Patient Name _____ Date of Birth _____

Primary Care Physician _____

Influenza Vaccine
Check the one that fits best:
_____ Received a flu vaccine this flu season
_____ Did not receive a flu vaccine this flu season because of medical reasons
_____ Did not receive a flu vaccine this flu season because I don't want one

Pneumococcal Vaccine
_____ Received a Pneumococcal Vaccine (Pneumovax)
_____ Did not receive a Pneumococcal Vaccine

Advanced Directives
Advance Directives are designed to respect your wishes about life-saving medical treatment if you are unconscious or incapacitated

Which statement(s) best reflects your wishes on advanced care recommendations?
_____ **Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation (CPR) efforts to be made (full code)
_____ **Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life
_____ **Do Not Intubate:** I do not wish to have a breathing tube inserted, even if it is necessary to save my life

Do you have a living will? Y / N

If yes, do you have a health care proxy named in the event you are unable to make your medical decisions? Y / N

If yes, Proxy's name _____

Proxy's phone number _____

Patient signature _____ Date _____

Medical History

Past Medical History (circle all that apply)

Alzheimer's/ Dementia
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Benign Prostatic Hyperplasia
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Acid Reflux
Hearing Loss
Heart Attack
Hepatitis (Type: A, B, C)
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pulmonary Embolism
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

List any condition not listed above _____

Past Surgical History (circle all that apply)

Appendix Removed
Urinary Bladder Removed
Mastectomy (Right, Left, Both)
Breast Lumpectomy (Right, Left, Both)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy (Surgical Colon Bypass)
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Transplant
Heart: Coronary Angioplasty
Joint Replacement Hip (Right, Left, Both)
Joint Replacement Knee (Right, Left, Both)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Removed
Liver Transplant
Liver Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas Removed
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP: Prostate Resection
Rectum: Repair
Rectum: Resection
Spleen Removed
Testicles Removed (Right, Left, Both)
Hysterectomy: Cervical Cancer
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

List any surgery not listed above _____

Skin Disease History (circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburn
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/ Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Other (any condition not listed above) _____

Do you tan in a tanning salon?	Yes	No	
Do you wear sunscreen daily?	Yes	No	If yes, what SPF? _____
Family history of Melanoma?	Yes	No	If yes, which relative? _____

Name of Preferred Pharmacy _____ **Pharmacy zip code** _____

Medications (please attach a list of medications if needed and it will be returned to you)

Drug	Dose	Route	Frequency
Ex. Simvastatin	20mg	by mouth	1 tablet daily

_____

_____

_____

_____

_____

Allergies (please list all allergic reactions)

_____

_____

_____

Social History (circle all that apply)

Cigarette Smoking
Never Smoked
Former Smoker
Current Smoker

Alcohol Use
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Males under 65: How many times in the past year have you had 5 or more drinks in one sitting? _____

Males 65+ and Females: How many times in the past year have you had 4 or more drinks in one sitting? _____

Family Medical History (only list conditions affecting your *parents*, *siblings*, and/or *children*)

_____

_____

Review of Systems (circle all that you are ***currently*** experiencing)

Problems with bleeding
Problems with scarring
Rash
Immunosuppression
Hay Fever
Chest Pain
Fever or Chills
Night Sweats
Unintentional Weight Loss
Thyroid Problems
Blurry Vision
Abdominal Pain
Bloody Stool
Bloody Urine
Joint Aches
Muscle Weakness
Headaches
Seizures
Cough
Shortness of Breath
Anxiety
Depression

Medical Alerts (circle all that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Heart Valve
Artificial Joint Replacement
Blood Thinners
Defibrillator
MRSA
Pacemaker
Require Antibiotics Before Procedures
Rapid Heartbeat with Epinephrine
Pregnant or Attempting Pregnancy

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