



Acct:	
Appt. Date:	
Appt. Time:	
Doctor:	
Entered By:	
Verified By:	

**PLEASE CORRECT/ COMPLETE INFORMATION BELOW**

<b>Name:</b> (Circle one) Mr., Ms., Mrs., Miss, Dr., Rev.		<b>DOB: :</b>
<b>Preferred Name:</b>		<b>SSN:</b>
<b>Address:</b>		<b>Employer/School:</b>
<b>City, State, Zip:</b>		
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>Contact Phone #:</b>		<b>Gender:</b>
<b>Referring Physician:</b>		<b>Primary Care Physician:</b>
<b>Race:</b>		<b>Preferred Language:</b>
<b>Ethnicity (Circle one): Hispanic/Latino/a OR Not Hispanic/Latino/a</b>		<b>Email:</b>
<b>Emergency Contact:</b>	<b>Phone:</b>	<b>Relationship to Patient:</b>

**\*Please list all people with whom we are authorized to discuss and share any/all of the patient's PHI, including the patient's spouse, parents, relatives, legal guardians, school authorities, and/or other caregivers. We may be unable to disclose any PHI to anyone not identified on this list, including immediate family members.**

I understand that I have a right to revoke this authorization at any time by notifying Dermatology Group of the Carolinas in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)

First Name	Last Name	Relationship to Patient

Primary	Secondary
Insurance Co.	Insurance Co.
Insurance ID#	Insurance ID#
Group Name or #	Group Name or #
Employer (If Group)	Employer (If Group)
Insured Party's Name	Insured Party's Name
Insured Party's Address (if different from above)	Insured Party's Address (if different from above)
Insured Party's DOB	Insured Party's DOB
Insured Party's Soc. Sec. #	Insured Party's Soc. Sec. #

**FOR MEDICARE AND MEDICAID PATIENTS ONLY**

The information given by me in applying for payment under Medicare, Medicaid, and/or Medicare Supplement is correct. I request that payment of authorized benefits under these programs be made either to me or on my behalf to Dermatology Group of the Carolinas for any service furnished to me by that physician/provider. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services to the Centers for Medicare and Medicaid Services.

**FOR ALL PATIENTS**

I authorize Dermatology Group of the Carolinas to release any necessary PHI to my Primary Care Physician or any Specialist Physician I am referred to for further treatment. I hereby authorize Dermatology Group of the Carolinas to release any necessary PHI to any insurance companies when making a claim on my behalf. I further authorize payment of these medical benefits to Dermatology Group of the Carolinas for these services, if applicable. I understand this authorization allows the release of all PHI in my record.

**I understand the payment of any copay, coinsurance, and/or deductible is due at the time of service.**  
**I understand I am responsible for any services rendered not covered by insurance and/or the unpaid account balance.**  
**I understand that pathology specimens obtain may need to be sent out for additional testing.**

**COMMUNICATION CONSENT**

May we leave a message regarding laboratory and pathology test results? Please circle: Yes or No  
May we leave a message regarding your next appointment? Please circle: Yes or No

**Preferred Method of Contact for appointments:** Phone/Text/Email

\*NOTE: If you provide your email address, you will receive an invitation to join our patient portal.

\_\_\_\_\_  
Signature of Patient (or Patient's Representative)

\_\_\_\_\_  
Date

**Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement  
Proficiency of Language Assistance Services**

**ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you.  
Call 1-704-784-5901 to find out more details.**

**ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-704-784-5901**

**Consent For Treatment**

I am a patient at Dermatology Group of the Carolinas. By signing this form, I consent to be treated by the providers of this practice. My provider may require more facts about my health. I, Patient X. Test, agree to let the providers of this practice and staff do lab tests, screening tests, diagnostic tests, and routine exams. I understand that no promises have been made to me about the results of any treatment or services.

**CANCELLATION/NO-SHOW POLICY**

In the event you are unable to attend your appointment, we request that you cancel your appointment at least **forty-eight (48) hours** prior to your scheduled appointment. Please call **704-784-5901**, option **6**, at any time to notify us of the cancellation.

Patients who fail to show for their appointment without providing at least **twenty-four (24) hours' notice**, will be considered a no-show. After a patient's third no-show, he/she could be subject to dismissal from the practice.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how we protect the privacy of your PHI, the permitted uses and disclosures of your PHI, and your rights regarding such use and disclosure. **By signing this form, you acknowledge that you have had an opportunity to review our Notice of Privacy Practices.**

**ACCOMPANY MINOR**

**I hereby grant the following people (over 18 years of age) permission to bring my child for medical care and I grant the following people the authority to make medical decisions regarding my child on my behalf:**

**Name :** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name :** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

*I have read and understand the above policies.*

\_\_\_\_\_  
Signature of Patient (or Patient's Representative)

\_\_\_\_\_  
Patient Name (Please Print)



Account #  
 Patient:  
 Birth Date:  
 Age:  
 Doctor:

**Pharmacy Information**

Pharmacy Name:	
Pharmacy Phone #:	
Pharmacy Street Name:	
Pharmacy City:	
Pharmacy State:	

Medications, including over-the-counter (Yes  No )

	Medication Name:	Dosage	Notes
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Drug Allergies (Yes  No )

	Allergy	Reaction	Notes
1.			
2.			
3.			
4.			
5.			
6.			

Patient Past Medical History (Check if applicable)

Details

Asthma	<input type="checkbox"/>	
Lung Disease (COPD)	<input type="checkbox"/>	
Lung Infection /Cough	<input type="checkbox"/>	
Allergies (seasonal)	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	
Irregular Heartbeat	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	
Anti-Coagulation (Blood Thinners)	<input type="checkbox"/>	
Phlebitis/ Inflamed Blood Vessels	<input type="checkbox"/>	
Abnormal Bleeding Disorder	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	

Hepatitis B or C Infection	<input type="checkbox"/>	
AIDS/ HIV Infection	<input type="checkbox"/>	
Decreased Immune System	<input type="checkbox"/>	
Lymph Node Enlargement	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Sore Joints or Muscles	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	
Bowel Disease	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	
Menstrual Cycle Irregularities	<input type="checkbox"/>	
Cancer (Internal) - - Please note type	<input type="checkbox"/>	
Sun Sensitivity /Disorders	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	
Keloids (forms thick scars)	<input type="checkbox"/>	
Rash to Bandages or Tapes	<input type="checkbox"/>	
MRSA Infection	<input type="checkbox"/>	
Other History	<input type="checkbox"/>	
- No Pertinent Past Medical History	<input type="checkbox"/>	

**Skin History**

**Notes**

Actinic Keratosis "Pre cancers"	<input type="checkbox"/>	
Basal cell carcinoma	<input type="checkbox"/>	
Squamous cell carcinoma	<input type="checkbox"/>	
Abnormal Mole (s)	<input type="checkbox"/>	
Malignant Melanoma	<input type="checkbox"/>	
Other Lesions	<input type="checkbox"/>	
Acne	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	
Psoriasis	<input type="checkbox"/>	
Rosacea	<input type="checkbox"/>	
Urticaria /Hives	<input type="checkbox"/>	
Other Skin History	<input type="checkbox"/>	
- No significant skin history	<input type="checkbox"/>	

**Surgical History**

**Details**

Pacemaker/Defibrillator	<input type="checkbox"/>	
Heart By-Pass/Heart Stents	<input type="checkbox"/>	
Artificial Heart Valve	<input type="checkbox"/>	
Transplant	<input type="checkbox"/>	
Artificial Joint	<input type="checkbox"/>	
Cochlear Implant	<input type="checkbox"/>	
Vagal Nerve Stimulator	<input type="checkbox"/>	
Other Surgeries – 1	<input type="checkbox"/>	
Other Surgeries – 2	<input type="checkbox"/>	
None	<input type="checkbox"/>	

**Patient Family History**

**Afflicted Family Member**

**Notes**

Adopted	<input type="checkbox"/>		
Malignant Melanoma	<input type="checkbox"/>		
Other Skin Cancer	<input type="checkbox"/>		
Other Family History	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>		
Eczema	<input type="checkbox"/>		
Psoriasis	<input type="checkbox"/>		
Seasonal Allergies	<input type="checkbox"/>		

- No Contributing Family History	<input type="checkbox"/>		
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**Social History**

Alcohol Use

- Does not consume alcohol
- Consumes alcohol socially
- Consumes alcohol daily
- How many times in past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? \_\_\_\_\_ Times

Recreational Drug Use

- Does not use recreational drugs
- Admits to using recreational drugs

Pregnancy

- Pregnant
- Planning on becoming pregnant
- Breast feeding

Tobacco History

- I have never smoked/used smokeless tobacco
- I am a former smoker/smokeless tobacco user:  
Start date \_\_\_\_\_ Quit Date \_\_\_\_\_
- I am a current smoker.
- I am a current smokeless tobacco user.

Occupation: \_\_\_\_\_

Have you ever received a Pneumonia vaccine?  
If yes: Month \_\_\_\_\_ Year: \_\_\_\_\_

Tanning Bed Use

- Currently uses
- Previously used
- Has never used