GEORGIA SKIN CANCER
& Aesthetic Dermatology

PATIENT CLIPBOARD: HISTORY & INTAKE FORM
(Please Print)

Patient: _____ **Date of Birth:** _____ **Medical Record #:** _____

Alerts/Past Medical History: (Please circle all that apply)

Alerts:
Blood Thinners
Defibrillator
Pre-meds Prior to Procedure
HIV/Hepatitis
Pregnant/Nursing

NONE
Anxiety Disorder
Arthritis
Atrial fibrillation
B-cell lymphoma
Chronic obstructive lung disease
Coronary arteriosclerosis
Cutaneous T-cell lymphoma
Depressive disorder
Diabetes mellitus
Disease caused by 2019-nCoV
Elevated blood pressure
End-stage renal disease
Epilepsy
Gastroesophageal reflux disease
H/O: hypertension
Hearing loss
Human immunodeficiency virus infection
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory disease of liver
Leukemia
Malignant lymphoma
Malignant neoplasm of bone
Malignant tumor of body of pancreas
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of lung
Malignant tumor of prostate
Primary cutaneous lymphoma
Radiation therapy treatment management
Transplantation of bone marrow
Other: _____

Past Surgical History: (Please circle all that apply)

NONE
Abdominoperineal resection
Bilateral replacement of knee joints
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
H/O: colostomy
H/O: tubal ligation
History of appendectomy
History of bilateral mastectomy
History of cholecystectomy
History of colectomy
History of tissue graft heart valve
History of total cystectomy
History of transurethral prostatectomy
Hysterectomy
Kidney biopsy
Low anterior resection of rectum
Lumpectomy of breast
Lumpectomy of left breast
Lumpectomy of right breast
Mastectomy of left breast
Mastectomy of right breast
Mechanical heart valve replacement
Oophorectomy
Pancreatectomy
Prostatectomy
Prosthetic arthroplasty of hips
Splenectomy
Surgical of biopsy of skin
Total nephrectomy
Total orchidectomy
Total replacement of left hip joint
Total replacement of left knee joint
Total replacement of right hip joint
Total replacement of right knee joint
Transplantation of heart
Transplantation of liver
Other: _____

Medical Record #: _____

Skin Disease History/Sun Exposure: (Please circle all that apply)

NONE	**H/O: asthma**	**Pruritus of skin**
Acne	**H/O: hay fever**	**Psoriasis**
Actinic keratosis	**Infection of skin**	**Rosacea**
Basal cell carcinoma of skin	**Light-for-dates with signs**	**Squamous cell carcinoma**
Contact dermatitis	**of fetal malnutrition**	**Sunburn of second degree**
Dry skin	**MRSA Infection**	**Tinea corporis**
Dysplastic nevus of skin	**Malignant melanoma**	**Tinea pedis**
Eczema	**Pityriasis versicolor (tinea)**	**Other: _____**

Do you wear sunscreen? **YES NO** What SPF? **_____** Do you tan in a tanning salon? **YES NO**

Do you have a family history of Melanoma? **YES NO** If yes, what relative? _____

Medications: (Please list - or attach list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies/ Drug Allergies: (Please list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Social History:

Smoking History: □ **Currently Smoke** □ **Have Smoked in the Past** □ **Never Smoked**

Alcohol Consumption: □ **None** □ **< 1 drink per day** □ **1-2 drinks per day** □ **>3 drinks per day**

All patients please sign:

- I authorize the release of any medical information needed to process Medicare and/or other insurance.
- I authorize Georgia Skin Cancer and Aesthetic Dermatology to treat the above named patient (including minors) as necessary.
- I authorize the release or acquisition of any medical information to/from any physician or physician's office, laboratory, pharmacy, hospital, or surgical facility involved in my care. I have read the HIPAA privacy policy of Georgia Skin Cancer & Aesthetic Dermatology.

Signature: _____ **Date:** _____

Signature of Patient, Parent or Legal Guardian

Medical Record #: _____

GEORGIA SKIN CANCER
& Aesthetic Dermatology

PATIENT DATA:
(Please Print)

Patient Information:

Name: _____ □Jr. □Sr.
First Middle Last

Nickname (if applicable): _____ **Date of Birth:** _____
Month/Day/Year

Sex: □ Male □ Female **Marital Status:** _____ **Social Security #:** _____

Contact Information:

Patient Home phone #: _____ **Patient Cell phone #:** _____
Preferred contact number: HOME CELL **May we leave voicemail on this number? YES NO**

Email address: _____

Mailing Address:

_____
Address City State Zipcode

Emergency Full Name: _____ **Phone #:** _____
Spouse Full Name: _____ **Phone #:** _____
Caretaker Full Name: _____ **Phone #:** _____

Guarantor:
For patients under 18, we must document a guarantor. Skip this section if the patient is 18 or older.
Patient's Relationship to Guarantor (circle): SPOUSE CHILD EMPLOYEE OTHER: _____
Guarantor's Name: _____ □Jr. □Sr.
First Middle Last
Guarantor's Date of Birth: _____
Guarantor's Mailing Address (if different from patient's):

_____
Address City State Zipcode

Guarantor's Home phone #:_____ **Guarantor's Cell phone #:**_____
Guarantor's Email address: _____

Medical Record #: _____

Release of PHI:

May we discuss your medical condition with any member of your household? **YES NO**

If yes, who? **SPOUSE PARENT CHILD FRIEND OTHER**

Name: **_____Phone #: _____ (CELL / HOME)**

Name: **_____Phone #: _____ (CELL / HOME)**

Name: **_____Phone #: _____ (CELL / HOME)**

Pharmacy:

Pharmacy Name: _____ **Location OR Phone #:** _____

Practice Data:

Primary Care Provider: _____

Referring Provider (if applicable): _____

Patient Referral Source:

How did you hear about us? _____

If patient is a Minor: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____ _____ _____

Signature of Parent/Legal Guardian Printed Name of Parent/Legan Guardian Date of Birth Date

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

_____ _____

Signature of Patient, Parent or Legal Guardian Date