COASTAL DERMATOLOGY, INC

400 Commercial Court
Savannah, GA 31406
Phone: 912.352.3535
Fax: 912.352.3485

PERSONAL INFORMATION

First Name	M.I.	Last Name	Female / Male	Social Security #	Date of Birth	Age

Street Address	Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Other ____

City	State	Zip Code	Home Phone	Work Phone	Cell Phone

Patient Employer	Patient Profession	Department

Name of Spouse	Spouse Employer	Spouse Contact #

Emergency Contact	Emergency Contact Employer	Emergency Contact #

Referring Physician

FINANCIAL INFORMATION

Person Financially Responsible for Services Rendered	Relationship to Patient

Street Address	City	State	Zip Code	Home Phone	Cell Phone

Employer	City	State	Zip Code	Department	Work Phone

INSURANCE INFORMATION

Primary Insurance Information

Name of Insurance	Paper Claims Mailing Address of Insurance		Contact #
Name of Subscriber	**Subscriber's Relationship to Patient**		**Subscriber's Date of Birth**
Policy/ID #	**Group #**	**Effective Date of Coverage**	**Specialist Copayment**

Secondary Insurance Information

Name of Insurance	Paper Claims Mailing Address of Insurance		Contact #
Name of Subscriber	**Subscriber's Relationship to Patient**		**Subscriber's Date of Birth**
Policy/ID #	**Group #**	**Effective Date of Coverage**	**Specialist Copayment**

AUTHORIZATION TO RELEASE INFORMATION TO INSURER: I hereby authorize Coastal Dermatology, Inc. to release to my insurer information acquired in the course of my treatment.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Coastal Dermatology, Inc. for the surgical and/or medical benefits for any medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. I understand my insurance will be filed as a courtesy only. I understand that should my insurance not respond in a timely manner that I will be billed for the balance due. I understand that non covered services by my insurance will be my responsibility and I will be billed for the balance due. Any copays, coinsurance, deductibles, and noncovered services must be paid at time ofservice. If noninsured payment must be paid in full at time of service. I further understand that all balances must be paid within 30 days of first statement; if not paid within 30 days there will be a finance charge added to the balance.

Signature of insured person, parent, or guardian_____

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION: I hereby authorize Coastal Dermatology to share any personal health information with the following persons:

Name_____Relationship to Patient_____Contact #_____

Name_____Relationship to Patient_____Contact #_____

Name_____Relationship to Patient_____Contact #_____

Signature of patient, parent, or guardian_____

PATIENT ACKNOWLEDGMENT OF UNDERSTANDING OF COASTAL DERMATOLOGY. INC.'S PRIVACY PRACTICES

Patient's name:_____Date of birth:_____

SSN:_____ Previous name (If applicable)_____

I understand that the patient's health information is private and confidential. I understand that Coastal Dermatology, Inc. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Coastal Dermatology, Inc. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Coastal Dermatology, Inc. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available in our office. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Coastal Dermatology, Inc. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Coastal Dermatology, Inc. will provide me with the most current "Notice of Privacy Practices."

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Coastal Dermatology, Inc. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Coastal Dermatology, Inc. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Coastal Dermatology, Inc.'s "Notice of Privacy Practices".

_____

Date Time

Relationship to patient: ____Self ____Parent ____Legal Guardian ____Personal Representative:_____

PATIENT:_____

SKIN LESION HISTORY

Have you noticed any of the following changes in a mole, wart, or spot on your skin:

NO	YES	Size (larger or smaller)
NO	YES	Color (redness, darker or lighter
NO	YES	Surface Characteristics (scaling, crusting, flaking, bleeding, oozing, etc.)
NO	YES	Consistency (getting hard, soft, lumpy)
NO	YES	Shape or Outline (irregular, notched border, raised above the surface)
NO	YES	The Surrounding Skin (spread of pigment or color from the edge of a mole into skin that used to appear normal
NO	YES	Change in Sensation (soreness, stinging, burning, tingling, hurting)
NO	YES	Sudden appearance of a new pigmented spot in an area that used to be normal

Do you have trouble taking any local anesthetics? NO YES

Do wounds on your skin heal slowly or form large scars or keloids? NO YES

MEDICATION ALLERGIES

Aspirin	Penicillin	Codeine	Morphine
Sulfa Drugs	Erythromycin	Tetracycline	Other_____

MEDICATIONS

List all medicines, even if you only take them occasionally. Please include laxatives, tranquilizers, sleeping pills, antihistamines, vitamins, aspirin, pain pills, blood thinners, birth control pills, blood pressure pills, etc.

Date Began	Medication	Date Discontinued

DATE_____ SIGNATURE:_____

PATIENT:_____

FAMILY AND SOCIAL HISTORY

What is the reason for this office visit?_____

How long have you had this problem? _____

Have you been treated by another doctor for this problem? No Yes

If yes, who and when? _____

Do you feel this problem is work related? No Yes

Have you been treated for a previous skin disease (rash, acne, eczema, etc)? No Yes

If so, who and when? _____

Are you presently taking any medication? No Yes (If yes, see page 2)

Are you allergic to any medications? No Yes (If yes, see page 2)

OTHER ALLERGIES		
Food	NO	YES
Ointment, Creams, Lotions	NO	YES
Makeup	NO	YES
Jewelry	NO	YES
Insects	NO	YES
Hay Fever, Sinus, Asthma, Eczema	NO	YES
Other_____		
_____		
HEART AND VESSELS		
High Blood Pressure	NO	YES
Enlarged Heart(Heart Failure)	NO	YES
Angina	NO	YES
Phlebitis	NO	YES
Irregular Beats	NO	YES
Heart Pacemaker	NO	YES
Valve Disease or Prolapse	NO	YES
LUNGS		
Asthma	NO	YES
Emphysema	NO	YES
Blood Clots	NO	YES
INTERNAL		
Ulcer Disease	NO	YES
Gallbladder	NO	YES
Colitis or Inflammatory Bowel Disease	NO	YES
Pancreatitis	NO	YES
Hepatitis	NO	YES
DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY FORM OF CANCER?		
Skin	NO	YES
Melanoma	NO	YES
Other_____		
_____		
HAVE YOU BEEN HOSPITALIZED DURING THE PAST THREE YEARS?	NO	YES
For what condition?_____		
_____		
_____		

KIDNEY		
Kidney Stones	NO	YES
Prostate Infection	NO	YES
Bladder infection	NO	YES
Kidney Failure	NO	YES
GYNECOLOGY		
Vaginal Infection	NO	YES
Are menstrual periods abnormal or irregular?	NO	YES
Are you pregnant?	NO	YES
If yes, how many months?_____		
Are you currently using birth control pills?	NO	YES
ARTHRITIS	NO	YES
ENDOCRINE		
Thyroid Disorder	NO	YES
Diabetes	NO	YES
BLOOD		
Anemia	NO	YES
Bleeding or Clotting Disorder	NO	YES
NEUROLOGY		
Do you sleep well?	NO	YES
Do you have problems with stress or nerves?	NO	YES
Stroke___ Paralysis___ Seizures___	NO	YES
SOCIAL		
Do you currently smoke?	NO	YES
Do you consume alcoholic beverages?	NO	YES
If yes, 2 or more drinks or beers per day?	NO	YES
FAMILY HISTORY		
Do any blood relatives (grandparents, mother, father, brothers, sisters, aunts, uncles) have any of the following? Do not consider yourself.		
Asthma Who_____	NO	YES
Hay Fever Who_____	NO	YES
Eczema Who_____	NO	YES
Psoriasis Who_____	NO	YES
Diabetes Who_____	NO	YES
Heart Disease Who_____	NO	YES
Other Skin Diseases Who_____	NO	YES

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Our goal is to provide the best dermatological care to our patients. Each time we remove a mole, cancer or pre-cancerous lesion, a sample is sent for microscopic evaluation. This evaluation allows us to treat you more appropriately. All biopsies taken in our office are sent to an outside laboratory for processing.

It is the patient's responsibility to know which lab/pathology your insurance requires you to use.

Please notify us immediately upon check-in and list on the line below if your insurer requires you to use any specific lab.

_____

Please read carefully and initial each line:

_____I understand all lesions removed will be sent to pathology.

_____I understand that a charge will occur for each specimen taken.

_____I understand that an additional pathology charge will occur for each and every specimen removed.

_____I understand that Coastal Dermatology, Inc., is not responsible for the billing of any labs. *Therefore, any billing questions should be directed to the lab performing and/or reading your pathology.*

_____

I have read and initialed each line above. Date