DERMATOLOGY AND SKIN SURGERY CENTER
210 Village Center Parkway
Stockbridge, GA 30281Phone: 770-474-5952

Dr. Juan A. Mujica
Dr. Neville G. Pereyo
Dr. Maria R. Pico
Grace Bogert, PA-C
Matthew Brunner, PA-C

Martha Sikes, PA-C
Christopher Golden, PA-C
Dr. Mark Baucom
Dr. David Pharis

**Patient Information** ***Please Print*** **Today's Date** _____/______/______

Last Name ______________________ First Name ______________________ Middle Initial __________

Social Security Number ________________________________________________

Address No PO Boxes ________________________________________________

City ______________________________ State and Zip ______________________________

( ) - ( ) - ( ) -

Home Phone Work Phone Cell Phone

Date of Birth MM / DD / YY ______________ Current Age ______________

Sex MALE OR FEMALE ______________ Martial Status ______________

**Patient or Responsible Party (If different from patient)**

Last Name ______________________ First Name ______________________ Middle Initial __________

Address ________________________________________________

City ______________________________ State and Zip ______________________________

( ) - ( ) - ( ) -

Home Phone Work Phone Cell Phone

Date of Birth MM / DD / YY ______________ ______________

Sex MALE OR FEMALE ______________

Relationship of patient to the Insured ______________________________

## INSURANCE INFORMATION (Please present insurance card at time of check in)

| | | | |
|---|---|---|---|
| Primary Insurance Name | ___ | Secondary Insurance Name | ___ |
| Name of Insured | ___ | Name of Insured | ___ |
| Insured's ID # | ___ | Insured's ID # | ___ |
| Group # | ___ | Group # | ___ |
| Pharmacy of Choice | ___ | Phone | ___ |
| In case of Emergency, who should be notified? | ___ | Phone | ___ |

Referred by: ___

Primary Care Physician: ___

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ___ Today's Date ___/____/____

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of ash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductibles, non-covered services and copayments.

In the event you must cancel a surgical or cosmetic appointment, we must be notified at least 48 hours prior to your appointment time. If not, you will be charged a $50 cancellation fee for a surgical appointment and your cosmetic deposit will be forfeited. All unpaid balances over 90 days will be charged a $2.00 per month finance charge. After 120 days of non-payment, an additional $10.00 charge will be added and your account will be forwarded to an outside collection agency.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ___ Today's Date ___/____/____

☐ **Copy of insurance card (both sides) attached.** ☐ **Updated by:** ___

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**NON-COVERED SERVICES**

I understand that the following procedures / services are usually considered as **non-covered services**. If I request medical or surgical treatment for these diagnoses, I will be responsible for the fees.

- Acrochordons (Skin Tags)
- Alopecia (Hair Loss)
- Benign Nevi (Moles)
- Hair Removal (Waxing, Elctrolysis, Laser)
- Lentigo (Liver Spots, Age Spots)
- Keloid (Injections/Surgery)
- Dermabrasion
- Scar Revision/Acne Scarring
- Seborrheic Keratosis
- Facials
- Spider Veins (Leg and Facial)
- Tattoo Removal
- Dilated Blood Vessels
- Liposuction
- Laser Surgery/Consult
- Injections (Cortisone)
- Chemical Peels
- Milia (Cysts)
- Ear Piercing
- Male Pattern Baldness
- Split Earlobe Repair
- Sebaceous Hyperplasia
- Wrinkles

**PLEASE READ – OUR FINANCIAL POLICY**

- All cosmetic surgeries/procedures are to be paid for in full, prior to procedure being done.
- All co-payments will be collected upon completion of the Patient Information Sheet or at sign-in prior to seeing the physician.
- If we are not a provider for your insurance, or if you have not met your deductible, or are ineligible for benefits, FULL PAYMENT WILL BE COLLECTED TODAY.
- Deposits for procedures are non-refundable.
- All billed balances must be paid within 30 days of 1st billed date, after which they are subject to collection efforts.
- All returned checks are subject to a $30.00 returned check fee.
- Tissue specimen will be sent to a Board Certified Dermatopathologist, who will bill a separate fee.

Patient signature (or guardian) ______________________________

Date ______________________________

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**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

I have the right to review the Notice of Privacy Practices prior to signing this consent.

1. With my consent, DERMATOLOGY AND SKIN SURGERY CENTER may use the following methods to communicate with me.
   **Call** to my home or other designated location and leave a message on voicemail or in person, **mail** to my home or other designated location, or **email** to my home or other designated location.

2. I also understand and consent that my personal health information may be disclosed to other appropriate entities, such as (but not limited to) my insurance company (ies), other physicians or health care providers and others as indicated in the Notice of Privacy Practices.

3. I have the right to request that DERMATOLOGY AND SKIN SURGERY CENTER restricts how it uses or discloses my personal health information. I request the following restrictions(s):

   The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. The above restrictions ARE, ARE NOT agreed to by DERMATOLOGY AND SKIN SURGERY CENTER.

   Signed: ____________________ Position/Title: ________________________ Date: _______________

4. If I do not sign this consent, DERMATOLOGY AND SKIN SURGERY CENTER may decline to provide treatment to me. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

By signing this form I am consenting to DERMATOLOGY AND SKIN SURGERY CENTER Use and disclose of my personal health Information (PHI) to carry out treatment, Payment, and operations (TPO).

I also authorize assignment of insurance benefits to DERMATOLOGY AND SKIN SURGERY CENTER.

_______________________________________
Signature of Patient or Legal Guardian

_______________________________________
Signature of Patient or Legal Guardian

_______________________________________
Patient's or Guardian's Printed Name

_______________________________________
Date

DERMATOLOGY AND SKIN SURGERY CENTER, LLP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ms. Vicki Heath, privacy Officer at 210 Village Center Parkway, Stockbridge, GA 30281.

**Please complete the following medical history form**

Name ______________________________ Today's Date ____________________

Age _____ Sex ______ Referring Doctor ________________________________

Reason for today's visit: ________________________________

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Skin areas involved: ________________________________

How long has the problem been present? ________________________________

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Was a biopsy done? ☐ No ☐ Yes ☐

Was there any previous treatment? ☐ No ☐ Yes - What ____________________

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**Please list all medications:** (Include vitamins, herbs, supplements)

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**Allergies:** ________________________________

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**Past Medical History (Circle all that apply):**

| | |
|---|---|
| Anxiety | GERD |
| Arthritis | Hearing loss |
| Artificial joints | Hepatitis |
| Asthma | Hypertension |
| Atrial fibrillation | HIV/AIDS |
| BPH | Hypercholesterolemia |
| Bone marrow transplant | Hyperthyroidism |
| Breast cancer | Leukemia |
| Colon cancer | Pacemaker |
| COPD | Prostate cancer |
| Coronary artery disease | Radiation Treatment |
| Depression | Seizures |
| Diabetes | Stroke |
| End state renal disease | Valve Replacement |

Other: ________________________________

None: __________________

Name ________________________________________

**Past Surgical History (Circle all that apply):**

Appendix removed
Bladder removed
Mastectomy (right,left, both)
Lumpectomy (right,left, both)
Breast reduction
Breast implants
Colectomy (diverticulitis)
Colectomy (IBD)
Gallbladder removed
Coronary artery bypass
PTCA
Valve replacement
Heart transplant
Joint replacement (which?)

Kidney biopsy
Kidney removed (right or left)
Kidney transplant
Ovaries removed: cysts
Ovaries removed (ovarian cancer)
Prostate removed (prostate cancer)
Prostate biopsy
TURP
Skin biopsy
Skin cancer surgery
Spleen removed
Testicles removed (right, left, both)
Hysterectomy (fibroids)
Hysterectomy (uterine cancer)

Other: ________________________________________________________________________

None: _________________

**Skin Disease (Circle all that apply):**

Acne
Actinic keratosis
Blistering sunburns
Dry skin
Eczema
Flaky/itchy scalp

Hay fever/allergies
Poison Ivy
Precancerous moles
Psoriasis
Skin cancer (melanoma, basal cell carcinoma or squamous cell Carcinoma)

Do you wear sunscreen? ☐ No ☐ Yes ☐ SFP ____________
Do you tan at a tanning salon? ☐ No ☐ Yes
Do you have a family history of melanoma? ☐ No ☐ Yes Who? ______________________________

**Social History (Circle all that apply)**

Currently smokes daily
Currently smokes occasionally
Has smoked in the past

Drug Use: __________________________

Sexual Partners: one or multiple

Name: ___________________________________________

**Review of Systems (Circle all that apply):**

Pacemaker

Defibrillator

Artificial joint within last 2 years

Artificial heart valve

Need premedication prior to procedures

Allergy to adhesives

Allergy to topical antibiotics

Taking blood thinners

Pregnancy/working on it

Allergy to lidocaine

Rapid heartbeat with epinephrine

Yeast infection with antibiotics

Problems with bleeding

Problems with healing

Problems with scarring (keloid and hypertrophy)

Immunosuppression

Changing mole

Rash

Abdominal Pain

Anxiety

Bloody stools

Bloody urine

Blurred vision

Chest pain

Cough/wheezing

Depression

Fever/chills

Headaches

Joint aches

Muscle weakness

Neck stiffness

Night Sweats

Shortness of breath

Sore throat

Unintentional weight loss