

**Patient Information for
The Center for Dermatology, P.C.**

PLEASE PRINT

A. **Patient's Name** _____ Gender M F
Last First Middle Preferred

Address _____ Date of Birth _____
Street City State Zip Code Mo. / Day / Year

Social Security # _____ **Home Phone** _____

Patient's Primary Insurance _____ Contract Number _____

Secondary Insurance _____ Contract Number _____

B. **Father's Name** _____ Date of Birth _____ SS # _____

Address _____

Employed By _____ Occupation _____

Business Address _____ Business Phone # _____

Name of Insurance Carrier _____ Contract Number _____

C. **Mother's Name** _____ Date of Birth _____ SS # _____

Address _____

Employed By _____ Occupation _____

Business Address _____ Business Phone # _____

Name of Insurance Carrier _____ Contract Number _____

D. Patient's Nearest Relative and Address (Other Than Parents) _____
Name

_____ Street City State Zip Code Home Phone #

E. Patient Referred By _____ Have you seen Dr. Morris before? _____

F. Allergies _____ Medications _____

Have you been told you have the following? (Please check all items either "yes" or "no")

| | | | | | |
|-------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| ALLERGY | Yes | No | AUTOIMMUNE DISEASE | Yes | No |
| Food | <input type="checkbox"/> | <input type="checkbox"/> | Lupus | <input type="checkbox"/> | <input type="checkbox"/> |
| Ointments, Creams Lotions | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Make-Up | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid | <input type="checkbox"/> | <input type="checkbox"/> |
| Jewelry | <input type="checkbox"/> | <input type="checkbox"/> | Scleroderma | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay fever, Sinus, Eyes | <input type="checkbox"/> | <input type="checkbox"/> | NERVOUS SYSTEM | Yes | No |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Hives | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Illness | <input type="checkbox"/> | <input type="checkbox"/> |
| CARDIOVASCULAR | Yes | No | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | RESPIRATORY | Yes | No |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | COPD, Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> | ARTHRITIS | <input type="checkbox"/> | <input type="checkbox"/> |
| BLOOD | Yes | No | HEPATITIS | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | BLOOD TRANSFUSIONS | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding or Clotting Disorder | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Any additional medical conditions _____

Has anyone in your family had a history of any of the following? (Please check all that apply)

| | | | |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Other Skin Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding Disorder |

OVER PLEASE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

“On behalf of my child, I give permission to The Center for Dermatology, P.C. to submit full medical records, within discretion, to my insurance companies if they so request and to other physicians that I am consulting if they so request.”

Parent’s Legal Signature Relationship
Date _____ Witness _____

ASSIGNMENT OF BENEFITS

“I hereby authorize any payment due on my child’s claim to be paid directly to The Center for Dermatology, P.C.”

Parent’s Legal Signature Relationship

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Center for Dermatology, P.C., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Center for Dermatology, P.C.’s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received the practice’s Notice of Privacy Practices prior to signing this consent. The Center for Dermatology, P.C. 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 The Center for Dermatology, P.C. Privacy Officer at 4310 Old Shell Road, Mobile, Alabama 36608.

With my consent, The Center for Dermatology, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, The Center for Dermatology, P.C. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to The Center for Dermatology, P.C.’s use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, The Center for Dermatology, P.C. may decline to provide treatment to me.

Patient or Legal Guardian Signature Date

For minor patients 14 years of age and older:

“I hereby give consent for my parent or parents to be present during my medical treatment at The Center for Dermatology, P.C. and I realize that I will have to notify the Privacy Officer in writing at The Center for Dermatology, P.C. if these wishes change.”

Signature of Patient Date