PEACHTREE DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

PATIENT REGISTRATION FORM

371 E Paces Ferry Rd NE, Ste 900
Atlanta, GA 30305
Tax ID 581089205

Patient Information:

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: _____

City/State: _____ Zip Code: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Primary Phone: _____E-mail Address: _____

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment Reminders, administrative updates and health bulletins) Yes No

Other Information:

Primary Care Physician: _____ Date of Last Visit? ___/___/___

Address/Location: _____ Next Expected Visit? ___/___/___

How did you hear about our Practice? _____

Preferred Pharmacy:

Pharmacy Name: _____ Address: _____

Pharmacy Phone: (____) _____ Pharmacy Fax: (____) _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

Emergency Contact:

Name: _____ Address: _____

Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Number: _____Policy Holder's Date of Birth: _____/_____/_____

Copay Amount $_____ Sex: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Peachtree Dermatology Associates, PC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Patient / Guarantor Signature *_____ Date _____

***If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge that PDA has given me the opportunity to read a detailed notice of their Privacy Practices.

Patient / Guarantor Signature *_____ Date _____
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If not signed, please provide a reason why the acknowledgement was not obtained.

Witness _____ Date_____
Staff Signature

CONSENT TO RELEASE INFORMATION
In the event I cannot be reached, I, _____, give permission for a representative from PDA, to speak with family member (s) or companion (s) listed below regarding care or tests results.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Is it OK to leave results or information on your voicemail? _____ Yes _____ No

Patient / Guarantor Signature *_____ Date _____
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CONSENT TO CORRESPOND ELECTRONICALLY
While PDA takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with a PDA physician regarding my medical care, that PDA physician and /or his/her representative has my permission to correspond via that email address.

I give permission for a PDA physician or clinical staff member to email me at

_____@_____ regarding my medical care.

Patient / Guarantor Signature *_____ Date _____
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FINANCIAL DISCLOSURE STATEMENT

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Thank you for choosing Peachtree Dermatology (PDA). You can expect to receive the following bills as a result of your visit:

- Physician Fee: Fee to be paid to the physician for performing the service. This bill will be from PDA.
- Lab Fee: If a lab test is ordered, a second bill will come from an outside lab.
- Pathology Fee: When a pathology test is ordered, a second bill will come from an outside pathology lab.

Insurance: Your insurance company will send you an Explanation of Benefits (EOB) that will explain how the insurance company paid your bill. The EOB will also explain any amount for which you may be responsible. Some insurance plans require you to pay different out of pocket amounts based on the where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. PDA will submit primary, secondary and tertiary claims of our contracted payers on your behalf as long as the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit, the patient or guarantor is responsible for the balance.

Co-payments: PDA collects co-payments at the time of service. Additional payment may be required based on your insurance plan. In the event your account has a credit a refund will be issued in a timely manner.

Refunds: All refunds will be processed within 3-5 weeks after the overpayment is discovered on the patient's account or at the time the refund is requested. Patients who have insurance but made a partial payment or payment in full will not be refunded until payment is received in full from their insurance company. Refunds for prepaid events will be processed within 5-7 business days. For refunded payments a check will be issued to the patient.

Initial below:

_____If we are unable to verify you have active coverage on the date of your appointment you will be required to pay for the visit in full at the time of service. If your insurance later pays for your visit we will issue you a refund.

_____In the event that you are unable to keep your appointment, please reschedule at least 48 hours in advance. A missed office appointment will result in a $40 fee. A missed cosmetic/aesthetic appointment will result in a $75 fee.

_____A $45 fee will be incurred for returned checks.

Additional questions regarding billing or payment arrangements should be directed to our billing department as follows:
Call the office at 404-355-1919 Ext. 342 and 343 and ask to speak to the billing department.

_____In the event we need to contact you regarding a billing matter, we may call you on your cell phone if you have listed this number as your primary or alternate contact number

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Patient's Reassignment and release statement

By signing below, I indicate my understanding of PDA's billing practices and that I may receive multiple bills related to my office visit as explained above. I authorize payment of medical benefits to PDA and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan. This agreement applies to all visits that take place one year from the date this is signed, and any bills resulting from those visits.

Patient / Guarantor Signature *_____Date_____
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PATIENT MEDICAL HISTORY

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Patient Name _____MRN# _____Date _____

Reason for today's visit _____

Who is your primary care physician?_____

Who referred you to us? _____

Please check those medical conditions that apply to you (this information is kept confidential).

____Heart Disease
____Heart Murmur/Artificial heart valve
____Stroke
____Pacemaker
____Gastrointestinal Problems
____Hypertension
____Poor Healing
____Diabetes
____Endocrine or Hormone Problems
____Skin Cancer
____Seizure Disorders
____Cancer
____Herpes Infections
____Arthritis
____Breathing Difficulties
____HIV Positive
____Sexually Transmitted Diseases
____Tuberculosis
____Seasonal Allergies
____Shingles
____Hepatitis/Liver disease/Jaundice
____Blood Clotting Disorders
____Asthma / Hayfever
____Kidney Disease
____Ulcers
____ Other (Please explain below)

Please explain any conditions checked above _____

_____

Please list **ALL MEDICATIONS** you are currently taking (including aspirin, laxatives, birth control pills, vitamins, etc.)

Drug name	**Dosage (strength)**	**Frequency taken (ex: daily, as needed)**

ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.)_____

_____

DRUG ALLERGIES (list all known) _____

_____

Do you have a family history of skin cancer? _____Yes ____No
If so what type?_____
Do you have changing/suspicious moles? _____Yes ____No
Unusual colors or bleeding? _____Yes ____No
Are you pregnant or nursing? _____Yes _____No
If no to pregnancy, are you trying? _____Yes ____No
1st day of last menstrual cycle?_____
Do you use tobacco/ smokeless tobacco? _____Yes ____No
Frequency? _____
Do you drink alcohol? _____Yes ____No
Frequency?_____
Are you taking a blood thinner like Coumadin or aspirin?
_____Yes ____No
If so, which?_____

Do you have a heart problem or artificial joint that requires you to take antibiotics before a surgical or dental procedure? ____ Yes ____No

Have you received the flu vaccine this season?
____ Yes ____No

****65 and older only****
Have you ever had the Pneumonia vaccine? ____ Yes ____No
Do you have an Advance Care Directive or living will? ____Yes ____No
Indicate whom you have named as your surrogate decision maker?
_____
(Please ask our front office staff for a free Advance Care Directive, if you don't currently have one)

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.

Patient / Guarantor Signature *_____ Date _____

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