



PATIENT REGISTRATION FORM

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

PEACHTREE DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Nickname: _____ Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____ Sex: M / F (Circle One) Marital Status: Single/Married/Divorced/Widowed/Domestic Partner

Contact Information

Preferred contact Method? Phone / Email / Patient Portal (Circle One)

Mobile Number: _____ - _____ - _____ Alternate Number (Home / Work): _____ - _____ - _____

Is it OK to leave a detailed message on your voicemail? YES / NO (Circle One)

Email Address: _____@_____

Would you like to opt-in to email notifications regarding appointments, administrative updates, health bulletins, and marketing information?

YES / NO (Circle One) (You may unsubscribe at any time)

Emergency Contact Full Name: _____ Phone Number: _____ - _____ - _____

Relationship to Patient: _____

Address Information

Street Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Information

Primary Insurance Company: _____ Policy/Member/ID #: _____

Group Number: _____ Effective Date of Coverage: ____/____/____ Policy Holder: _____

Policy Holder's Date of Birth: ____/____/____ Claims Mailing Address: _____

Provider Customer Service Phone Number: _____ - _____ - _____

Secondary Insurance Company: _____ Policy/Member/ID #: _____

Guarantor (person responsible for bill, if different from patient)

Guarantor Name: _____ Relationship to Patient: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____ Phone Number: _____ - _____ - _____

Guarantor's Address: _____ City: _____ State: _____ Zip code: _____

Preferred Pharmacy

Pharmacy Name: _____ Address: _____

Pharmacy Phone Number: _____ - _____ - _____ Pharmacy Fax Number: _____ - _____ - _____

Primary Care Physician

Physician's Name: _____ Address: _____

Physician's Phone Number: _____ - _____ - _____ Physician's Fax Number: _____ - _____ - _____

I attest that the information on this form is accurate and complete to the best of my knowledge. I authorize Peachtree Dermatology Associates, PC to release any medical information necessary to process claims through my insurance company(s). I authorize my insurance benefits to be paid directly to Peachtree Dermatology Associates, PC. I understand that I am financially responsible for any balance, 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.



By providing your mobile number, you agree to receive text messages from Peachtree Dermatology, which may include:

- Appointment reminders
 - o Patient Signature: _____

- Treatment updates, billing notifications, and occasional marketing messages related to our dermatology services
 - o Patient Signature: _____

Message frequency may vary. Message and data rates may apply.

You may opt out of receiving text messages at any time by replying STOP. For assistance, reply HELP or contact our office directly.

Consent to receive text messages is not a condition of receiving care. You may revoke your consent at any time.

We may use third-party service providers to facilitate messaging. Your mobile information and SMS consent will not be shared with third parties or affiliates for marketing or promotional purposes.

Patient Printed Name

Patient Signature

Date

Mobile Phone Number



NOTICE OF PRIVACY PRACTICES

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Peachtree Dermatology Associates, PC (PDA) has given me the opportunity to read a detailed notice of their Privacy Practices.

(A copy is posted for the general public at the front desk, and online at www.peachtreedermatology.com under "About Us" and "Privacy Policy", or a printed copy can be made available upon request)

Patient / Guarantor Signature*: _____ **Date:** _____

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

If not signed, please provide a reason why the acknowledgement was not obtained:

Witness (Staff) Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from PDA to speak with the appointed person(s) listed below regarding my care or test results.

Name _____ Phone _____

Relationship to Patient _____

Name _____ Phone _____

Relationship to Patient _____

Is it OK to leave results or other health information on your voicemail? _____ YES _____ NO (Check One)

Patient / Guarantor Signature*: _____ **Date:** _____

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PATIENT PORTAL CONSENT

While PDA takes reasonable precautions to protect your confidential health information, email is not a completely secure method of communication. Therefore, PDA strongly encourages the use of our secure patient portal to communicate electronically. PDA's Patient Portal allows patients to review and update their medical record, schedule appointments, access test results, and send private messages through encrypted transmission. We will generally use your email address to activate your patient portal access.

I give permission for PDA to enable my portal access. _____ YES _____ NO (Check One)

I confirm that my email address is _____@_____

Patient / Guarantor Signature*: _____ **Date:** _____

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FINANCIAL DISCLOSURE STATEMENT

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Thank you for choosing Peachtree Dermatology Associates, PC (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 medical 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: It is the responsibility of the patient to verify whether PDA is “in-network” with their insurance plan. You may call your insurance provider and give them our Tax ID number, #58-1089205, to verify your in-network benefits. We are credentialed through Piedmont Healthcare, and we submit claims to most insurance plans with which Piedmont Healthcare participates. You reserve the right to request that PDA not submit a claim to your insurance plan for medical services. However, you must pay for those medical services out-of-pocket, in full. You may revoke this option at any time to begin submitting claims to your insurance plan. To protect against fraud you must present your insurance card at each visit, and we must have a government-issued photo ID on file. PDA will submit primary, secondary and tertiary claims to our contracted payers on your behalf, as long as the information 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 partial payment or payment in full will not be refunded until their claim has been processed and paid. Refunds for prepaid events will be processed within 5-7 business days.

Telehealth: All telehealth visits require a \$75 deposit to be scheduled. We will submit telehealth claims to your insurance plan, if this information has been provided. Any credit resulting from this initial deposit will be refunded as outlined above.

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 information is later provided, and the plan pays for your visit after we have submitted your claim, we will issue you a refund as outlined above.

_____ 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 each returned check.

Additional questions regarding billing or payment arrangements should be directed to our billing department as follows:
Call the office at **404-355-1919**, select option 5 for 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.

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 my 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-payment, co-insurance, deductible and non-covered services amounts as outlined by my health plan. This agreement applies to all visits that take place one year from the date this form is signed, and any bills resulting from those visits.

Patient / Guarantor Signature*: _____ **Date:** _____

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PATIENT MEDICAL HISTORY FORM



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Patient Name _____ Date _____

Reason for today's visit _____

Who is your primary care/referring physician? _____

If this is your first visit, how did you hear about us? _____

Please check those medical conditions that apply to you:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endocrine or Hormone Problems | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sexually Trans. Diseases |
| <input type="checkbox"/> Asthma / Hayfever | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Heart valve, artificial | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Poor Healing | <input type="checkbox"/> Other (please list below) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes Infections | <input type="checkbox"/> Seasonal Allergies | |
| | | <input type="checkbox"/> Seizure Disorders | |

Please explain any conditions checked above _____

Please list **ALL MEDICATIONS** you are currently taking (including aspirin, birth control pills, & vitamins). Continue on back of sheet, if needed.

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

ALLERGIES (list all known allergies) _____

DRUG ALLERGIES (list all known medication allergies) _____

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? _____

Are you taking a blood thinner? _____ **YES NO**

If so, which one? _____

Do you have a heart problem or artificial joint that requires you to take antibiotics before surgical or dental procedures? _____ **YES NO**

Have you been hospitalized in the last 30 days? _____ **YES NO**

If so, when? _____

Tobacco Use

Do you use tobacco (in any form)? _____ **YES NO**

How frequently? _____

Alcohol Use

Do you drink alcohol? _____ **YES NO**

How frequently? _____

COVID-19

Have you been infected with COVID-19? _____ **YES NO**

Have you received the COVID-19 vaccine? _____ **YES NO**

If yes, which of the vaccines did you receive and when?

Flu Season only (Oct-March)

Have you received the flu vaccine this season? _____ **YES NO**

Women only

Are you pregnant or nursing? _____ **YES NO**

If not, are you trying to conceive? _____ **YES NO**

1st day of last menstrual cycle? _____

65 and older only

Have you ever had the Pneumonia vaccine? _____ **YES NO**

If you cannot make your own medical decisions, do you have an Advance Care Directive or a living will? _____ **YES NO**

Indicate whom you have named as your surrogate decision maker/healthcare proxy? _____

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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