

*The Dermatology Center of Newton - Rockdale*

**PATIENT INFORMATION**

*(Please Print)*

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Marital Status S / M / W / D Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Employer \_\_\_\_\_

**RESPONSIBLE PARTY or LEGAL GUARDIAN (if different from patient)**

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ SS# \_\_\_\_\_

**INSURANCE INFORMATION (Please Provide Insurance Card(s) and Driver's License to be copied & kept on file)**

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

**ADDITIONAL INFORMATION**

Other family members that are patients \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Date of last physical \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MEDICARE PATIENTS**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

*By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, of its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment off medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.*

*By signing below I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.*

*The Dermatology Center of Newton - Rockdale*

**RELEASE OF INFORMATION**

By signing below I authorize the release of any or all medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions.

**TREATMENT**

Consent is hereby voluntarily given for staff, nurse practitioner or physician's assistant, and physicians to provide such diagnostic procedures and to provide such treatment and care as in the opinion of treating physician may be necessary or appropriate. I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. It has been explained that medicine is not an exact science, and that no guarantee has been made as to the results of the treatment or care rendered. This consent has been fully explained and its contents are understood.

**PAYMENT AND INSURANCE BENEFITS**

By signing below I authorize direct payment of medical benefits to The Dermatology Center of Newton/Rockdale, Joseph T. Overton, Jr., M.D. for services rendered. I understand that I am financially responsible for any balance not covered by insurance including co-payments, co-insurance, and deductibles. All accounts over 90 days past due will be sent to collections. If my account is turned over to a collection agency, I understand that all collection fees will be added to this account balance.

To the best of my knowledge, the questions on this form have been accurately answered. My signature below acknowledges that I have read and understand each of the preceding sections.

**PRIVACY NOTICE ACKNOWLEDGEMENT**

I acknowledge that I have reviewed / received a copy of the Summary Privacy Notice for Joseph T. Overton, Jr., M.D. Privacy Notice Revision Date: April 14, 2003

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

By signing below I, hereby authorize Joseph T. Overton, Jr., M.D., The Dermatology Center of Newton/Rockdale to release my protected health information (medical or billing) to the following: *(Please check and provide the name or specific entities to whom your protected health information may be given.)*

Name/Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ or Last 4 digits of SS#: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ or Last 4 digits of SS#: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ or Last 4 digits of SS#: \_\_\_\_\_

May we leave personal medical / billing information on your answering machine at home? \_\_\_\_\_ Yes \_\_\_\_\_ No

<b>Patient / Personal Representative's Signature:</b> _____	<b>Date:</b> _____
<b>Patient / Personal Representative's Name Printed</b> _____	<b>Relationship</b> _____

<b>By signing below, I acknowledge that I have reviewed all attached information and confirm that it is still correct and in effect.</b>	
<b>Date Updated</b> ____/____/____	<b>Patient / Representative's Signature</b> _____
<b>Date Updated</b> ____/____/____	<b>Patient / Representative's Signature</b> _____
<b>Date Updated</b> ____/____/____	<b>Patient / Representative's Signature</b> _____

## PATIENT HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Place a check mark in front of the condition which describes you or your family member.

Have you or any relative ever had  Answer to all is no

- |  |  |
|--|--|
| <p style="text-align: center;">Which Relative</p> <ul style="list-style-type: none"> <li><input type="radio"/> Eczema _____</li> <li><input type="radio"/> Asthma _____</li> <li><input type="radio"/> Psoriasis _____</li> <li><input type="radio"/> Melanoma _____</li> <li><input type="radio"/> Other Skin Disorder _____</li> </ul> | <p style="text-align: center;">Which Relative</p> <ul style="list-style-type: none"> <li><input type="radio"/> Hay Fever _____</li> <li><input type="radio"/> Hives _____</li> <li><input type="radio"/> Skin Cancer _____</li> <li><input type="radio"/> Allergies _____</li> </ul> |
|--|--|

**Past History**

- Diabetes
- Eczema
- Problems with Healing
- Syphilis
- Heart Disease Type
- Lung Disease

**Have You Had?**

- HBP
- Hay Fever
- Drug Allergies
- Herpes
- Coumadin / Blood Thinner
- Peptic Ulcer

Answer to all is no

- Tuberculosis
- Asthma
- Tonsillitis
- AIDS
- Hepatitis
- Lupus

**Medical Illness/Hospitalizations/Surgical Operations**  None

Year _____	Illness _____	
Year _____	Illness _____	
Year _____	Illness _____	
Year _____	Illness _____	

Habits: Check the ones which apply and the amount consumed per day

- None Apply       Alcohol       Tobacco       Drugs       Other

**Do you have any medication allergies?** \_\_\_\_\_

Name of Medication & Dose	Date Started	Date Stopped

Nurse's signature and review date:
