We welcome you to Peterson Dermatology. In order to make your visit more pleasant, please take a few moments to read this letter and complete the enclosed forms.

When you come for your appointment on ________________, please bring these forms with you completed to the best of your ability. You will also need to bring your insurance card(s) and your driver’s license or non-driver picture ID. (Proper ID is required for treatment.) Also, you will need to be prepared to pay your co-pay at the time of service.

All minors must be accompanied by a parent/legal guardian before the patient can be seen by the doctor.

Office visits and treatments not covered by insurance are payable at the time of service. As a courtesy to you, we will file your insurance claim at no charge. We are providers of Medicare and Blue Cross; and we participate with most commercial insurance plans.

We are located across from Harvey’s grocery store in Vidalia. Our office is open Monday through Thursday 8:00 to 5:00 and Friday 8:00 to 12:00. We are closed for lunch from 12:00 to 1:00.

We look forward to having you as our patient.
Peterson Dermatology
Patient Registration

PATIENT INFORMATION:

First Name: ___________________________ MI __________ Last Name: ___________________________

Social Security #: ____ / ____ / ____ Date of Birth: ____ / ____ / ____

Marital Status ( S M W D ) or Child: ______ Sex: Male ____ Female ____

Mailing Address: ___________________________ Apt. # ______ Phone #: ___________________________

City: __________ St: __________ Zip: __________ Cell #: __________________________

Race: _______ Ethnicity: Hispanic/Latino or Not Hispanic/Latino ________ Preferred language: ________

*Which physician referred you or how did you hear about us? __________________________

*Have we treated any of your family members or close friends, if so please list: __________________

*Please list your pharmacy, location and phone #: __________________________

EMPLOYER INFORMATION:

Employer: ___________________________ Phone #: __________________________

EMERGENCY CONTACT

Name: ___________________________ Relationship: ___________________________

Home Phone #: __________________ Secondary Phone #: __________________

INSURANCE INFORMATION:

Primary Insurance Company: ___________ Policy #: ___________ Group #: ___________

Policyholder Name: __________________ Date of Birth: ____ / ____ / ____ SS#: __________________

Secondary Insurance Company: ___________ Policy #: ___________ Group #: ___________

Policyholder Name: __________________ Date of Birth: ____ / ____ / ____ SS#: __________________

MINOR INFORMATION:
IF PATIENT IS A MINOR (18 YEARS OR YOUNGER) PLEASE FILL OUT THE FOLLOWING:

Mother’s Name: ___________________________ Phone #: ___________________________

Father’s Name: ___________________________ Phone #: ___________________________

A Parent or Legal Guardian Must Be Present For Any Treatment of Minors!!

PLEASE READ AND SIGNED BELOW

I/We, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. I hereby authorize Peterson Dermatology to furnish information to insurance carriers concerning my illness and treatments. It is customary that payment be made when the service is rendered. I authorize benefits payable to the above physician. I understand that I am responsible for any amount not covered by insurance.

_________________________ ___________________________
Date Patient/Responsible Party Signature
Peterson Dermatology
Policies

Patient Name: ____________________________

MISSED APPOINTMENT POLICY
Your appointment time has been reserved especially for you. If you cannot keep your appointment, you must call at least 24 hours in advance to cancel or reschedule. If you are more than 15 minutes late, you must reschedule. If appointments are missed without notice, you will be charged a missed appointment fee. If you miss a regular visit your account will be charged $25. If you miss a surgery appointment your account will be charged $100 for excisions and $200 for MOHs surgery.

MEDICAL RECORDS POLICY
Your medical record is the property of Peterson Dermatology. We will send all pertinent information to any doctor we refer you to at no charge to you. If you move out of the area and transfer care to another Dermatologist, we will also forward necessary records at no charge. However, there will be a charge for any other request for medical records as allowed by Georgia Law.

***INSURANCE POLICY***
PLEASE REMEMBER THAT YOUR INSURANCE POLICY IS CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU (THE PATIENT) ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF YOUR MEDICAL BILLS.

1) Many services we provide are considered “COSMETIC” or “NOT MEDICALLY NECESSARY.” Obvious examples are Botox and other wrinkle treatments. Less obvious examples of cosmetic / non-medically necessary services after removal of non-cancerous skin growths such as moles or skin tags that are not painful, bleeding, irritating, or have other symptoms. We are happy to provide these services to you; however, it is unethical and illegal to bill your insurance company for them. Growths that are suspicious, cancerous, or have symptoms such as bleeding or pain are covered by insurance.

2) We prescribe individual treatments based on what is the best for you and your condition. Sometimes generic drugs are helpful and are cost effective. GENERIC DRUGS ARE NOT ALWAYS EQUIVALENT TO BRAND NAME DRUGS. Many times they are not as effective or have more side effects because of different delivery molecules or inactive ingredients. Your insurance company is motivated to have you use only drugs on their formulary. We are motivated to give you the best, safest, and most effective treatment. We will Attempt to get non-formulary drugs approved, but ultimately the decisions between you and your insurance company.

3) Co-pays and deductibles are due at time of service.

4) There will be a $30 fee on all returned checks.

MINORS: All services rendered to minor patients will be the financial responsibility of the parents/guardian.

• I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_________________________  _____________________________
Date                     Signature of Patient/Guardian
New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I, ____________________________, understand that as part of my health care, Peterson Dermatology originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that my protected health information (PHI) serves as:

- A basis for planning my care and treatment,
- A means for communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Peterson Dermatology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted.

I further understand Peterson Dermatology reserves the right to change their notice and practices. Should Peterson Dermatology change their notice, they will send a copy of any revised notice to the address I’ve provided.

LIST

<table>
<thead>
<tr>
<th>I give permission to disclose my PHI to: (family members)</th>
<th>I do not give permission to disclose my PHI to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, i.e., lab, treatment/testing facility, insurance company, physician or pharmacy, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent. I further acknowledge that I have received a statement of the privacy practices.

If no names are listed on this from your PHI will not be disclosed to anyone other than yourself.

________________________________________
Patient/Guardian Signature

________________________________________
Date

FOR OFFICE USE ONLY

( ) Consent received by ____________________________ on ____________________________

( ) Consent refused by patient, and treatment refused as permitted.

( ) Consent added to the patient’s medical record on ____________________________
# Peterson Dermatology

**Dermatology Medical, Family, and Social History**

Please fill out form completely and return to receptionist

## Patient Name:

## Reason(s) for today’s Visit:

Do you now have, or have you ever had:

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Yes</th>
<th>No</th>
<th>Another Condition</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td></td>
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<td>Allergies/Hay Fever</td>
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<tr>
<td>Heart Attack or Bypass</td>
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<td>Stroke</td>
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<tr>
<td>Pacemaker or Defibrillator</td>
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<td>Diabetes</td>
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<tr>
<td>Artificial Heart Valve</td>
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<td>Cancer</td>
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<tr>
<td>Rheumatic Fever</td>
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<td>Thyroid Disease</td>
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<tr>
<td>Heart Murmur</td>
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<td>Kidney Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<td>(Men) Enlarged Prostate</td>
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<td></td>
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<tr>
<td>Blood Clot in Leg or Lung</td>
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<td>Hepatitis</td>
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<tr>
<td>Phlebitis</td>
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<td>Glaucoma</td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Artificial Joints</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Women) Are you pregnant?  □ Yes □ No If yes, due date:

Have you ever had skin cancer? □ Yes □ No If yes, what kind (basal cell, squamous cell, melanoma) and where on your body?

Do you have a history of any specific skin diseases (for example, psoriasis or eczema)? □ Yes □ No If yes, list:

List any other disease or condition we should know about:

List any major surgical procedures you have had:

List all medications you are currently taking:

Are you allergic to any medications? □ Yes □ No If yes, list:

Have you ever had lidocaine or dental anesthesia (Novocain)? □ Yes □ No

If yes, did you have any bad reaction to it? □ Yes □ No

Do you drink alcohol? □ Yes □ No If yes, how many drinks per week?

Have you ever used tobacco? □ Yes □ No If yes, what type and how much?

Have you ever used IV drugs? □ Yes □ No

What is your occupation?

What are your hobbies?

When you are exposed to the sun do you (circle one): □ Tan only □ Burn then Tan □ Burn only

Has anyone in your family had skin cancer? □ Yes □ No If yes, who and what type?

Has anyone in your family had severe skin disease? □ Yes □ No If yes, list:

---

**Patient/Responsible Party Signature**

**Date**

**Reviewed and Signed by Physician**

**Date**