Augusta DERMATOLOGY AND AESTHETICS CENTER

New Patient Demographics & Intake Form

PATIENT DEMOGRAPHICS:

Patient Full Name: _____

Address: _____City: _____ State:_____ Zip:_____

Home Phone: _____ Mobile Phone: _____

Date of Birth: _____ Gender: _____. Race: _____

Email Address (For access to our patient portal): _____

Preference for appointment reminder (Text or Email): _____

How did you hear about us? _____

Name of referring physician: _____

Have your parents, grandparents, brothers or sisters been diagnosed with Skin Cancer ? Yes No

If yes, Circle what kind: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Other

Name of your primary care physician: _____

Preferred Pharmacy name : _____

May we discuss your care with alternate contact persons or other caregivers? Yes No

If Yes , please list name _____

EMERGENCY CONTACT :

Name: _____ Phone #: _____

GUARANTOR INFORMATION: (Provide parent or guardian information if patient is a minor):

Name: _____

Date of Birth: _____

Relationship to patient: _____

Phone #: _____

Address: _____ City:_____State:___ Zip:_____

PRIMARY INSURANCE:

Name of Insurance: _____ Name of Policy Holder: _____

Policy #: _____ Insured's date of birth: _____

Group #: _____ Relationship to Patient: _____

SECONDARY INSURANCE:

Name of Insurance: _____ Name of Policy Holder: _____

Policy #: _____ Insured's date of birth: _____

Group #: _____ Relationship to Patient: _____

MEDICAL HISTORY:

Have you received treatment for any Major Medical Conditions? _____

_____

SURGERIES AND HOSPITALIZATION:

Please list prior major surgeries/procedures (Medical device implants, Replacements, Etc.) _____

_____

PRIMARY COMPLAINT:

Why are you seeing the doctor today? Please specify Right or Left if applicable.

_____

Date of onset symptoms: _____

Have you been treated for this problem before: Yes No

ALLERGIES & MEDICATION:

Medication Allergies (Reactions) : _____

_____

Latex allergy? Yes No Tape/Adhesive Allergy? Yes No

Blood Thinner? Yes No If Yes Which one? _____

Pace Makers ? Yes No

Defibrillator? Yes No

Joint Replacement more than 2 yrs ago? Yes No If yes what year ?_____

Medication List (or bring List) : _____

_____

_____

SOCIAL HISTORY (Smoking Status):

Current or Former smoker ? Yes No E-Cigarettes ? Yes No

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that
constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.
For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.
For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care. We may make your medical information available electronically through health information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also allows us to see health information about you from other participants in the healthcare exchange.
For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by
Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; asrequired by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation

NOTICE OF INDIVIDUAL RIGHTS
You have the following rights regarding medical information we maintain about you:
Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy at any time.
Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances
Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by. or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, and you must provide a reason that supports your request. We may deny your request for an amendment.
Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer
Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice
Right to Restrict Disclosures to Health Plan You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted.
Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services, Office of Civil Rights, Hubert
H. Humphrey Building, 200 Independence Ave., Washington, DC 20201. To file a complaint with the Practice, contact Privacy Officer, Legend Orthopedics, 811 13th St., Suite 20, Augusta, GA 30901. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I have received or been offered a copy of this Notice of Privacy Practices.

Signature:	Date: