# PATIENT REGISTRATION

Name:

Date of Birth:

Sex:

Guarantor Name (if patient is a minor):

Address: City:

State:

ZIP:

Primary Phone: (Primary Phone will be used for Appointment Reminder Calls)

Mobile Phone:

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: (circle one) Hispanic /Latino OR Non-Hispanic/Non-Latino Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Doctor/PCP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name & Location: Emergency contact:

Relationship: Phone #:

**Insurance company:** Policy Holders Name:

SS# Date of Birth: Relationship:

How did you hear about our practice?

# MEDICAL INFORMATION

Reason for today’s visit: Do you have any known **DRUG ALLERGIES**? Do you have HIV? Yes\_\_\_\_ No\_\_\_\_\_ Do you have a history of HEPATITIS? Yes\_\_\_\_ No \_\_\_\_\_ If so, what type: A\_\_\_\_\_B\_\_\_\_\_\_C\_\_\_\_\_

Do you have a personal history of skin cancer? Yes \_\_\_ No\_\_\_ / Personal history of malignant melanoma? Yes\_\_\_\_ No\_\_\_\_

Do you have a family history of malignant melanoma? Yes\_\_\_\_\_ No\_\_\_\_(please circle) mom dad brother sister or child

Do you drink alcohol? Yes\_\_\_\_ No\_\_\_\_ Do you smoke? Yes \_\_\_\_ No\_\_\_\_\_ (If Yes How many packs?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker? Yes\_\_\_\_ No\_\_\_\_ Are you pregnant? Yes \_\_\_\_\_No\_\_\_\_\_ Are you breastfeeding? Yes\_\_\_\_\_ No\_\_\_\_

Are you diabetic? Yes\_\_\_\_\_ No \_\_\_\_\_ Have high blood pressure? Yes \_\_\_\_ No \_\_\_\_\_

Mammogram: (month/year)\_\_\_\_\_\_\_\_\_\_\_\_\_ Colonoscopy: (month/year)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flu Vaccine: (month/year)\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia Vaccine: (month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

COVID Vaccine: \_\_\_No, \_\_\_Yes, If yes which vaccine:\_\_\_\_Moderna, \_\_\_\_Pfizer, \_\_\_\_Johnson & Johnson

# Initial appropriate categories, to agree that GDC may disclose the following information to your medical/billing records:

HIV/AID: \_\_\_\_\_\_\_\_Mental Health:\_\_\_\_\_\_\_\_\_ Substance abuse:\_\_\_\_\_\_\_\_ Sexually Transmitted Disease:\_\_\_\_\_\_\_\_ Pregnancy Information:\_\_\_\_\_\_\_\_\_

Please list, attach or give us a copy of all medications and reason you are taking them, including non-prescription, hormone pills, and aspirin:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Do we have your permission to:

Leave a message on your answering machine at home? Yes\_\_\_\_\_\_ No\_\_\_\_\_ OR Cell Phone Yes\_\_\_\_\_ No\_\_\_\_\_

Leave a message at your place of employment? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

Discuss your medical condition with any member of your household? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_

If yes, whom:

**All Patients Please Sign**

Relationship:

I authorize the release of any medical information needed to process Medicare and/or other insurance.

I authorize Georgia Dermatology Center to treat the above named patient (including minors) as necessary including biopsies, surgeries and prescriptions.

I authorize the release or acquisition of any medical information to/from any physician’s office, laboratory, pharmacy, hospital or surgical facility involved in my care. I have read the HIPPA privacy policy of Georgia Dermatology Center.

Signature of Patient/Guardian: Date: