Greenville Dermatology, LLC

M. Miller, MD R. Jetton, MD R. Patterson, LMA

(Please print and complete entire form)

Social Security #_____________________________Male__________Female__________

Name of Patient

First ______________________ Middle _________________ Last ______________________

Mailing Address

Street____ City _____________________

State ________ Zip ___________ E-Mail _______________________________________

Phone: Home _________________Work _________________Cell___________________

DOB_________________Age________Single_____Married_____Widowed_____Divorced___

Occupation______________________________Employer_____________________________

Spouse's

Name______________Employer____________Phone_____________DOB_________

Spouse's Social Security #____

Reason for

Appointment____

Referred By ____

Complete Only If Minor Or Student :

Father's Name___________________Employer___________________Phone_____________

SSN#____________________________ Date of Birth_________________________

Mother's Name__________________Employer___________________Phone_____________

SSN#____________________________ Date of Birth_________________________

Person responsible for Medical Bills: Name_____________________________________

Primary Ins.__________________________Secondary Ins.___________________________

Insurance and Fee Policy:

I understand that I am personally responsible for payment of all fees for professional services rendered by this office unless other arrangements have been made in advance. I also authorize Greenville Dermatology, LLC to release to my Insurance Co. any information concerning my healthcare, for the purpose of processing Insurance claims.

I understand the Privacy Notice for Greenville Dermatology, LLC.

Patient Signature/ Legal Guardian: ______________________________Date:______________

Greenville Dermatology, LLC

Health & Medication Information

Patient Name: ___________________________________

Pharmacy Name ________________________________ Phone: _________________________________

List all Prescription and NON-Prescription Medicines you are now taking:

____

Have you ever been allergic to or had any unusual reaction to a local anesthetic such as Novocain,

Xylocaine or Adrenalin? YES____ NO____

Have you ever been unusually sensitive to cold temperatures? YES____ NO____

Do you have a Heart Pacemaker? YES____ NO____ Do you Smoke? YES____ NO____

Are you Pregnant? YES____ NO____ Do you drink Alcohol? YES____ NO____

Are you allergic to Latex or Rubber? YES____ NO____

Circle if you have ever had one of the following:

Hepatitis or Liver Disease Tuberculosis Blood Transfusion Diabetes

Bleeding Disorder or Blood Disease Stomach or Intestinal Disease Large Scars of Keloids

Thyroid or Hormone Disease Heart Disease Arthritis or Muscle Disease

Blood Vessel Disease High Blood Pressure Cancer Kidney Disease

Sexually Transmitted Disease Positive HIV Test or AIDS Fever Blisters anywhere on Body

Artificial Joint or Heart Valve Epilepsy or Nerve Disease Lung Disease

Major Surgery (Please list) ____

If you have any allergies (Please lists): ____

Has anyone in your family had the same problem for which you are being seen?

____

Signature of Patient/Legal

Guardian:____Date:_____________________________

Greenville Dermatology, LLC

Notification of Information Sheet

Dear Patient:

Often during the course of your relationship with us, laboratory and pathology reports and other information is generated that we need to relay to you. Legally, we can only relay this information to you. In other words, we are not allowed to reveal this information to your spouse, fiancé, siblings, children or other significant person in your life, or leave it on an answering machine unless we have your permission to do so. By filling out this form and signing it, you will be telling us how you would like this information relayed to you, and you will be giving us permission to reveal this information to someone else or telling us that you do not want anyone else to get this information.

Please note: If you do not sign this form, we cannot release any information about you to anyone but you and we cannot leave this information on an answering machine. We will call and leave a message that you need to call us.

Please check all that apply:

I, ____ (enter your name), allow Greenville Dermatology and its employees to reveal information about my care:

________ONLY TO ME PERSONALLY

________ONLY TO ME OR MY SPOUSE _______________(name of spouse)

________ONLY TO ME OR_________________________(name of person)

________ON MY ANSWERING MACHINE

________TO ANYONE WHO ANSWERS MY PHONE NUMBER

________BY MAIL

________ONLY IN THE FOLLOWING MANNER: (be very specific)

____

____

Patient/Legal Guardian Signature: _______________________________________

Date: _______________________________________

Greenville Dermatology

Insurance and Fee Policy

I understand that I am personally responsible for payment of all fees for professional services rendered by this office unless other arrangements have been made in advance. I also authorize Greenville Dermatology, LLC to release to my Insurance Co. any information concerning my healthcare, for the purpose of processing Insurance claims.
I understand the Privacy Notice for Greenville Dermatology, LLC.

Authorization to Release & Receive Medical Information to Referring/Primary Care

I,____,
Hereby authorize and Greenville Dermatology to release and receive all relevant medical information acquired and required during the course of my treatment to:
_____My Primary/Referring Physician_________________________
_____Insurance Company (Medical and relevant Rx information)
_____Celligent Diagnostics (In case of Pathology) and/or other physician
(In case of consult referral)

I know that this information will not be disclosed to any outside source without my consent. Purpose of Disclosure: Continuation of Medical Care Authorization Expires: One Year from Date Signed

Patient or Legal Guardian :

Signature:________________________________

Date: ___________________________________