

DERMATOLOGISTS

of BIRMINGHAM

PATIENT DEMOGRAPHICS

First Name: _____ MI: _____ Last Name: _____ Suffix: _____ Nickname: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

DOB: ____/____/____ PHONE: Home #: (____) _____ - _____ Cell #: (____) _____ - _____

PCP or Referring Physician: _____ Employer: _____

Soc. Sec. Number: _____ - _____ - _____ Gender: _____ Marital Status: _____

Race: (Check all that apply)

- American Indian
- Asian
- Black/African American
- Native Hawaiian/Other Pacific Islander
- White

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Preferred Language:

- English
- Spanish
- Other _____

EMAIL ADDRESS

(By providing your email address, you are consenting to receive Dermatologists of Birmingham updates, offers, and access to your patient portal, from which you can unsubscribe at any time.)

RESPONSIBLE PARTY | GUARDIAN INFORMATION

If same as above check here:

Person Responsible for Account: _____ DOB: ____/____/____ Relationship: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

PHONE Home #: (____) _____ - _____ Cell #: (____) _____ - _____ Email: _____

INSURANCE POLICY INFORMATION

1st Insurance: _____ Contract #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: ____/____/____ Relationship of patient to policy holder: _____

2nd Insurance: _____ Contract #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: ____/____/____ Relationship of patient to policy holder: _____

3rd Insurance: _____ Contract #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: ____/____/____ Relationship of patient to policy holder: _____

SMOKING STATUS

- Never Smoked
- Current every day smoker
- Heavy tobacco smoker
- Light tobacco smoker
- Former smoker

If you have ever smoked, what year did you begin smoking? _____

If you are a former smoker, what year did you quit smoking? _____

Initials _____



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DRUG ALLERGIES | MEDICATIONS

Do you have any known DRUG allergies?

- Lidocaine
 Other _____

Current oral and topical Medications?

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:

Name: _____ Phone: (_____) _____ - _____ Relationship to Patient: _____

ADDITIONAL CONTACT INFORMATION

Preference for appointment reminders?

- Phone Call
 Text Message

If we call by phone, may we leave a message with personal information including test results on your Voicemail? Y N

May we discuss **appointment confirmation, lab/biopsy results, or any relevant medical information** with family members or friends? Y N
If yes, please list below:

First Name	Last Name	Relationship	Phone Number
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PHARMACY

Name: _____ Street/City: _____

Phone: (_____) _____ - _____ Zip code: _____

Initials _____

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WHO CAN WE THANK FOR YOUR VISIT TODAY?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Physician Referral _____ | <input type="checkbox"/> Phone Book |
| <input type="checkbox"/> Word of Mouth _____ | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Internet Search Engine (Google, Chrome, etc.) | o Facebook |
| <input type="checkbox"/> Insurance Website (BCBS, Aetna, etc.) | o Pinterest |
| <input type="checkbox"/> Advertisement _____ | o Instagram |
| <input type="checkbox"/> Other _____ | o Other _____ |

PATIENT POLICIES AND NOTICES

Guarantee of Payment

In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Dermatologists of Birmingham, insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees, and court costs if such be necessary, waiving now and forever the right of accept insurance assignment as a guarantee of full payment.

_____ (PLEASE INITIAL)

Assignment of Insurance Benefits and Release of Information

My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to Dermatologists of Birmingham. Furthermore, my signature below authorizes Dermatologists of Birmingham to release to my insurance company medical information regarding his treatment for the purposes of determining eligibility for and payment of charges for services rendered in connection with care.

_____ (PLEASE INITIAL)

Dermatologists of Birmingham reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ (PLEASE INITIAL)

ePrescribing

Dermatologists of Birmingham has implemented ePrescribing. ePrescribing sends your prescriptions over the internet to your pharmacy; keeping your personal information protected. ePrescribing also lets your doctor see important information- like drug interactions and your prescription history. I authorize, with the signature below, that Aesthetic Dermatology | Shelby Dermatology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes through ePrescribing software.

_____ (PLEASE INITIAL)

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that Dermatologists of Birmingham may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. Dermatologists of Birmingham have a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Dermatologists of Birmingham will provide me with the most current Notice of Privacy Practices. My signature below indicates that I have been given the chance to review such a copy of the Notice of Privacy Practices. My signature means that I agree to allow Dermatologists of Birmingham to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dermatologists of Birmingham has taken relying on this consent.

_____ (PLEASE INITIAL)

Patient or Responsible Party Signature: _____ Date: ____/____/____



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Media and Photography Release Form

Patient Name: _____ Date: _____

I am: The individual named above

The individual's parent/guardian/ legally authorized personal representative

I consent for medical photographs or videos to be taken of me/my child/the person for whom I am legally authorized to represent. I understand that the information may be used in my personal medical record, for purposes of medical teaching, or for informative medical media purposes via website or in office telecommunications and publications. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

Erin Fisher, Practice Administrator

Phone: (205) 621-9500

Email: efisher@shelbydermatology.com

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

I HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I HAVE GIVEN UP RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

Patient or Responsible Party Signature

**Any photographs or videos taken by Dermatologists of Birmingham will be obtained by the use of a camera or video recording device dedicated specifically for the above explained purposes. It will be maintained in a secure location and cleared of its memory after images are uploaded. At NO time will personal devices, such as cell phones, be used to obtain photographs or videos for use by Dermatologists of Birmingham.*