Garrott Dermatology
Patient Information

Patient Name: _____ Date: ____/____/_____
Reason for today's visit: _____

Past Medical History: (please check all that apply)

___ Anxiety
___ Arthritis
___ Asthma
___ Atrial Fibrillation (Irregular Heartbeat)
___ Bone Marrow Transplantation
___ Benign Prostatic Hypertrophy (Enlarged Prostate)
___ Breast Cancer
___ Colon Cancer
___ COPD
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ End Stage Renal Disease
___ GERD (Acid Reflux)
___ Hearing Loss
___ Hepatitis
___ HIV/AIDS
___ Hypertension (High Blood Pressure)
___ Hypercholesterolemia (High Cholesterol)
___ Thyroid Disease: High or Low (Circle One)
___ Leukemia
___ Lung Cancer
___ Lymphoma
___ Prostate Cancer
___ Seizures
___ Stroke
___ Other: _____

Past Surgical History: (please check all that apply)

___ Appendix Removed
___ Bladder Removed
___ Breast Biopsy (L, R, or Both)
___ Lump Removal (L, R, or Both)
___ Breast Removal (L, R, or Both)
___ Colon: Colon Cancer Resection
___ Colon: Diverticulitis
___ Colon: Inflammatory Bowel Disease
___ Colon: Colostomy
___ Gallbladder (Cholecystectomy)
___ Heart: Valve Replacement (Mechanical or Biological)
___ Heart: Coronary Artery Bypass Surgery
___ Heart: Transplant
___ Heart: PTCA (Angioplasty)
___ Joint Replacement: Knee (L, R, or Both)
___ Joint Replacement: Hip (L, R, or Both)
___ Kidney: Biopsy
___ Kidney: Stone Removal
___ Kidney Removal (L, R, or Both)
___ Liver Removal
___ Liver Transplant
___ Liver Shunt
___ Ovaries Removed:_____(Reason)
___ Ovaries: Tubal Ligation
___ Pancreas Removal
___ Prostate: Biopsy
___ Prostate Removal for Cancer
___ Prostate: TURP
___ Rectum: APR
___ Rectum: Low Anterior Resection
___ Skin: Basal Cell Carcinoma
___ Skin: Biopsy
___ Skin: Melanoma
___ Skin: Squamous Cell Carcinoma
___ Spleen Removal
___ Testicles Removal
___ Uterus Removal: _____(Reason)
___ Other: _____
_____

Skin Disease History:

___ Acne
___ Asthma
___ Basal Cell Cancer
___ Blistering Sunburns
___ Dry Skin
___ Eczema
___ Flaky or Itchy Scalp
___ Hay Fever/Allergies
___ Melanoma
___ Poison Ivy
___ Precancerous Lesions
___ Precancerous Moles
___ Psoriasis/Psoriatic Arthritis
___ Squamous Cell Skin Cancer
___ Other: _____

Do you wear sunscreen? ___Yes ___No
If yes, what SPF? ___
Do you tan in a tanning salon? ___ Yes ___No

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Patient Information

Do you have a family history of Melanoma? ___Yes ___No
If yes, what relative(s)? _____
Any other family history:_____

Medications: (Please enter all current medications including prescriptions, over-the-counter meds., vitamins, and herbals; the current dosage & frequency are also needed for each.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies:

1. _____ 2. _____
3. _____ 4. _____

Social History: (Please check all that apply)

Cigarette Smoking:

___ Never smoked
___ Quit: former smoker
___ Smokes less than daily
___ Smokes daily

Illicit Drug Use:

___ Drug Use
___ IV Drug Use

Alcohol Use:

___ Alcohol: none
___ Alcohol: less than 1 drink per day
___ Alcohol: 1-2 drinks per day
___ Alcohol: 3 or more drinks per day

Safety:

___ I feel safe at home.
___ I do not feel safe at home.

Do you have a pacemaker? ___ Yes ___ No
Do you have a defibrillator? ___ Yes ___ No
Do you bleed easily? ___ Yes ___ No
(WOMEN) Are you pregnant or planning pregnancy? ___ Yes ___ No
Do you have problems with healing? ___ Yes ___ No
Do you develop keloids (scars)? ___ Yes ___ No
Do you develop skin reactions to: __Latex __Lidocaine __Adhesive

Language: __English __Spanish __Vietnamese __Other: _____
Race: Caucasian __ Black/African American __ Asian __ Hispanic __ Native American __
Other: _____
Pharmacy: _____ **City**: _____

Signed by Patient/Patient's Representative: _____
Date signed: ___/___/___

Garrott Dermatology
Patient Information

Name: _____ _____ _____ Jr. ___ Sr. ___
First Middle Last

Street Address: _____ City: _____ Zip: _____ Phone: (___)_____

Social Security #: _____ Age: _____ Sex: _____ Date of Birth: _____

Patient's Employer: _____ Patient's Occupation: _____

Employer's Address: _____ Employer's Phone: (___)_____

Full Time?____ Part Time?____ Retired?____ Student?____ Name of School: _____

Spouse's name: _____ Spouse's SSN: _____ Spouse's DOB:_____

Spouse's Employer: _____ Spouse's Occupation: _____

Employer's Address: _____ Employer's Phone: (___)_____

Responsible Party: _____ Address: _____

Social Security #: _____ DOB: _____ Relationship to Patient:_____

Employer: _____ Address: _____ Phone #: (___)_____

Nearest Relative (not living with you): _____ Phone #: (___)_____

#1 Insurance Co. Name: _____ Policyholder's Name/SSN: _____ DOB: _____

#2 Insurance Co. Name: _____ Policyholder's Name/SSN: _____ DOB: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICES RENDERED, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE.** It is your responsibility to pay any balance not paid by your insurance. In the event the account is turned over for collection, the collection and/or legal fees, including attorney fees, shall be your responsibility. Your signature below indicates that you understand and accept this herein and authorize payment of medical benefits to the Doctor when assigned claim is filed.

Signature: _____ Date: _____

PLEASE PRESENT PHOTO ID & INSURANCE CARD(S) TO THE RECEPTIONIST TO MAKE COPIES.

Attention: Please be advised that Garrott Dermatology Clinic uses A.W. Dermatopathology & Skin Pathology for skin biopsies. If your insurance requires a specific hospital or lab or cultures or biopsies please let your provider know at time of service. All services performed by the hospital or lab are billed separately, and it is the patient's responsibility for payment.

In order for us to reach you regarding appointments or results, do we have your permission to leave a message on your:
Voicemail? ____ Place of employment? ____ Email? ____ Fax?____ If yes, provide fax #: _____
Do we have your permission to speak with anyone in your household regarding your medical condition? ____ Yes ___ No
If yes, whom? _____ Relationship _____

Garrott Dermatology
Patient Information

SEC. A: PATIENT GIVING CONSENT

NAME: _____ Address: _____

Phone: _____ Email: _____

Social Security #: _____ (In office use only) Patient #: _____

SEC. B: TO THE PATIENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protect health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Thomas C. Garrott, M.D.
Fellow of the American Board of Dermatology
Alan Crawford, PA-C
24 Marks Road
Ocean Springs, MS 39564
Tel: (228)872-8873 Fax: (228)872-8876

Right to Revoke: You have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving to you your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is being signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____ Relationship to Patient:_____