# *Carole L. Johnson, MD*
# *Dermatology*

1733 West Main Street, Suite 200
Dothan, AL 36301
Phone (334) 677-1690 Fax (334) 699-1465

**Minor Patient Registration Form**

First Name _____M.I._____Last Name_____
Preferred Name: _____
Mailing Address:_____Apt, Lot, Suite #_____
City:_____ State:_____ Zip:_____
Physical Address (if not the same) _____
DOB:_____ Age:_____ Sex: ___ Male ___ Female Student: ___ Yes ___ No
Race: White, Hispanic, Black or African American, Other
Ethnicity: **NOT** Hispanic or Latino Hispanic or Latino
Cell Phone #_____Home Phone #_____
Email:_____ We will send you an email with a link to access your patient portal (medical records and medication refill requests).
How do you prefer to be reminded about appointments: ___ Text ___ Email ___ Phone
Referring Physician (if applicable):_____
Primary Care Physician_____

**Responsible Party Contact Information** ***The adult/guardian who brings in child will be responsible for all co-pays and deductibles. We do not forward bills to other parties regardless of court rulings or divorce degrees. If requested, a receipt will be issued at the time of payment for your use. Please complete the following with your information.***

First Name:_____ M.I._____ Last Name: _____
Relationship to Patient:_____ Date of Birth:_____
Social Security #: _____ Driver License Number : _____ State _____
Address (if different form patient):_____
Phone Number: _____ Alternate Phone Number: _____

**Insurance Information: Check with your insurance company to see if you need a referral. Also check to see if we are in your insurance network. We are not responsible for missing referrals or out of network charges.**

**Primary Insurance**

Insurance Company:_____ Policy ID Number:_____
Cardholder's Name:_____ Relationship to Patient:_____
Cardholder's DOB:_____Cardholder's SSN_____

**Secondary Insurance**

Insurance Company:_____ Policy ID Number:_____
Cardholder's Name: _____Relationship to Patient: _____
Cardholder's DOB:_____Cardholder's SSN_____

I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including those amounts not paid by my insurance company. Also, I agree that to my knowledge the above information is the most accurate and up to date. I authorize the release of this information as well as the release of medical records, if necessary, for payment by my insurance carrier. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collection, any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws. Please note, there may be additional costs from outside laboratories, biopsies, cultures, and other medical specimens will be sent to an outside lab. It is the patient's responsibility to contact their insurance carrier with inquiries regarding network coverage for these facilities. Information on these facilities will gladly be supplied to the patient at their request.

**Responsible Party Signature:_____Date:_____**

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## Authorization for Verbal Release of Protected Health Information

**Standard Disclosure:**
I authorize Carole L. Johnson, MD Dermatology to discuss my medical history, diagnosis, treatment, prognosis, and financial, insurance and billing information with those listed below. I understand this may include information regarding testing, examination, and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as, confirmation of any appointment for me to be seen in the office, hospital or other physician's office.

**Parent(s)- Dad:**_____

**Mom:**_____

**Grand Parent(s):**_____

**Other:**_____

_____ **NO INFORMATION**

I do not authorize the release of any verbal information concerning my treatment, I understand that this includes confirmation of dates, times, locations, and any billing or financial information.

I consent and authorize the release of any test results to be left on my voice mail at:
Home____ Work____ Other____ This authorization will expire at the end of my treatment with Carole L Johnson, MD Dermatology unless I revoke this consent prior to that time.

_____ _____
**Signature of Patient (if 14 or older)** **Date**

_____ _____
**Responsible Party (if 13 or younger)** **Date**

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## Patient Acknowledgment and Consent

I have been given a chance to review a copy of Carole L. Johnson, MD's Notice of Privacy Practices, version effective December 4, 2014. I consent to the uses and disclosures of my health information as outlined in the Notice (A copy of the privacy notice is available upon request in our office).

_____ _____

**Signature of Patient (if 14 or older)**

**Signature of Parent or Legal Guardian/Representative (If 13 or younger)**

_____ _____

**Printed Name of Patient**

**Printed Name of Parent or Legal Guardian/Representative**

_____

**Date**

**Documentation of Failure to Obtain Signed Acknowledgement:**

On_____ I, _____ _____, an employee of Carole L Johnson, MD Dermatology presented this Acknowledgement of Receipt of Notice of Privacy Practices form to patient _____. The patient refused to provide a signature when requested.

## ePrescribing Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows us to see important information such as drug interactions and your prescription history. The benefit to you is less confusion over handwritten prescriptions or unclear phone calls, reduced possibility of medical errors, fewer trips to drop off prescriptions at the pharmacy, and a safer, faster, easier way to get your prescription filled.

_____ _____

**Patient Signature** **Date**

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**Patient Name**_____ **Date of birth**_____

**Primary Care Physician**_____

**Medical History**

| | | | |
|---|---|---|---|
| □ | NONE | | |
| □ | Anemia (low blood count) | □ | Hyper-thyroid disorder |
| □ | Anxiety | □ | Hypo-thyroid disorder |
| □ | Arthritis | □ | Seizures |
| □ | Asthma | □ | Stroke |
| □ | Atrial Fibrillation (Irregular Heartbeat) | | |
| □ | Cancer (what type?) _____ | | |
| □ | Coronary Artery Disease | □ | Seasonal Allergies |
| □ | Depression | □ | Blood Clotting Disorder |
| □ | Diabetes | □ | Blood Clots (deep venous thrombosis, Pulmonary Embolus) |
| □ | Heartburn/Reflux (GERD) | □ | Easy bruising |
| □ | Hepatitis | □ | Hay Fever |
| □ | High blood pressure (hypertension) | □ | Heart Valve Problems |
| □ | HIV/AIDS | □ | Lupus |
| □ | High cholesterol (hypercholesterolemia) | □ | Mental health issues |

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**Past Major Surgeries** (incl. joint replacements, organ transplants, pacemakers) □ NONE

_____

_____

**Do you require antibiotics before dental cleanings or surgical procedures due to a history of heart valve replacements, joint replacement, rheumatic/scarlet fever?**
_____YES _____NO

**Skin Disease History**

□ Pre-Cancers
□ Squamous Cell Carcinoma
□ Eczema/Dermatitis
□ Basal Cell Carcinoma
□ Melanoma
□ Psoriasis
□ Sensitive Skin
□ NONE

**Family Cancer History** (Mom, Dad, brothers, sisters only- not aunts/uncles, etc) □ NONE
□ Melanoma: (relationship) _____
□ Breast Cancer: (relationship) _____

**Medications** □ NONE
**Name, dosage and how many times a day/week taken (if long list please supply a list)**

_____

_____

_____

**Medication Allergies** (Medications that you are allergic to) □ NONE

_____

_____

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**Social History:**

Alcohol use: Yes _____ No _____
Tobacco Use: Yes _____ No _____

**Vaccinations:**

**Have you had?**

**Flu**: YES ____ NO ____
If yes, when was the date of last shot? _____

**Other Vaccines** Check all that apply.
____ Received one dose of meningococcal vaccine on or between my 11th & 13th birthday.
____ Received one tetanus, diphtheria, and pertussis vaccine (T-dap) on or before my 10th & 13th birthdays.
____ Received at least three HPV vaccines on or before my 9th & 13th birthdays,

**Language Spoken:** _____

**Race:** □ White □ Hispanic □ Black or African American □ Other
**Ethnicity:** □ Hispanic or Latino □ **NOT** Hispanic or Latino

**PHARMACY:**

Name _____

Address _____

City _____State_____

Patient signature if 14 or older: _____

Responsible Party signature if 13 and under: _____

Date: _____