Carole L. Johnson, MD
Dermatology

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

Patient Information

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:_____ Marital Status: __M __S __D __W
SSN:_____ Driver License #: _____ State: _____
Cell Phone #_____ Home Phone #_____
Email Address:_____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
Employer Name: _____ Work Phone #_____
May we contact you at work?__ Yes ___No Do you wish phone calls to be confidential? ___ Yes ___ No
How did you hear about our practice _____
Referring Physician (if applicable):_____
Primary Care Physician_____
Race: White, Hispanic, Black or African American, Other (please circle)
Ethnicity: **NOT** Hispanic or Latino Hispanic or Latino (please circle)

Emergency Contact Information:

Name:_____ Relationship:_____ Phone #: _____

Insurance Information: Check with your insurance company to see if you need a referral. We are not responsible for missing referrals. Also check to make sure we are in your insurance net work.

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. It is my responsibility to obtain any required referral to the physician and/or verify my insurance is in network with the physician. Any charges incurred by not doing so are my responsibility. Also, I agree that 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(s). 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. There may be additional costs from outside laboratories, biopsies, cultures, and other medical specimens will be sent to an outside lab. It is my responsibility to contact my insurance carrier with inquiries regarding network coverage for these facilities. Information on these facilities will gladly be supplied to me upon 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 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.

Spouse:_____

Children:_____

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 Deramtology unless I revoke this consent prior to that time.

_____ _____
Signature of Patient **Date**

_____ _____
Witness **Date**

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Patient Acknowledgment and Consent

I have been given been given a chance to review a copy of Carole L. Johnson, MD's Notice of Privacy Practices, version effective July 1, 2020. 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 **Date**

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

Printed Name of Parent or Legal Guardian/Representative

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)
□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation (Irregular Heartbeat)
□ Cancer (what type?) _____
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ Heartburn/Reflux (GERD)
□ Hepatitis
□ High blood pressure (hypertension)
□ HIV/AIDS
□ High cholesterol (hypercholesterolemia)
□ Hyper-thyroid disorder
□ Hypo-thyroid disorder
□ Seizures
□ Stroke
□ Seasonal Allergies
□ Blood Clotting Disorder
□ Blood Clots (deep venous thrombosis, Pulmonary Embolus)
□ Easy bruising
□ Hay Fever
□ Heart Valve Problems
□ Lupus
□ 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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Tobacco Use

□ Never Smoked
□ Smoke now- how much/often? _____
□ Quit smoking- when? _____

Social History

☐ Alcohol use (if yes, how many drinks per day?_____) ☐ NONE

Vaccinations

Have you had?

Flu: YES ____ NO ____ If yes, when was the date of last shot? _____
Shingles Shot: YES ____ NO ____ If yes, when was the date of last shot? _____
Pneumonia: (Patients 65 & older)
YES ____NO ____ If yes, what was the date of last shot? _____

Advanced Directives: Advance directives are designed to respect your wishes about future life-saving medical treatment if you are unconscious or incapacitated.

Which statement(s) best reflect your wishes on advanced care recommendations?

____ I want full cardiopulmonary resuscitation (CPR) efforts to be made (full code).
____ I do NOT want full cardiopulmonary resuscitation (CPR)

Do you have a living will? (This is for end-of-life medical care, in case you become unable to communicate your wishes/decisions) □ YES □ NO

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: _____ Date: _____