Carole L. Johnson, MD

Dermatology

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

PATIENT INFORMATION

Patient Type: ☐ Adult (18 or older) ☐ Minor (under 18)

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____

Mailing Address: _____ Apt/Lot/Suite #: _____

City: _____ State: _____ Zip: _____

Physical Address (if different): _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ D ☐ W

SSN: _____ Driver License #: _____ State: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Employer Name (adult): _____ Work Phone: _____

Race: ☐ White ☐ Hispanic ☐ African American ☐ Other: _____ ☐ Decline to answer

MINOR PATIENT / RESPONSIBLE PARTY — COMPLETE IF PATIENT IS UNDER 18

The adult/guardian who brings the child in will be responsible for all co-pays and/or deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. If requested, a receipt will be issued at the time of payment for your use.

Responsible Party First Name: _____ M.I.: ____ Last Name: _____

Relationship to Patient: _____ Date of Birth: _____

Social Security #: _____ Driver License #: _____ State: ____

Address (if different from patient): _____

Phone Number: _____

EMERGENCY CONTACT — COMPLETE FOR ADULT PATIENTS OR IF DIFFERENT FROM RESPONSIBLE PARTY

Name: _____ Relationship: _____ Phone #:_____

INSURANCE INFORMATION: Check with your insurance company to see if you need a referral and whether we are in your insurance network. We are not responsible for missing referrals or out-of-network charges. Insurance cards should be submitted electronically with this form or presented to the receptionist at the time of your appointment.

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 amounts not paid by my insurance company. It is my responsibility to obtain any required referral and/or verify my insurance is in network with the physician. I authorize release of this information and medical records, if necessary, for payment by my insurance carrier. I authorize use of this signature on all 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, without relief from valuation and appraisement laws. Please note there may be additional costs from outside laboratories, biopsies, cultures, and other medical specimens sent to an outside lab. It is the patient's responsibility to contact their insurance carrier regarding network coverage for these facilities.

Responsible Party / Patient Signature: _____ Date: _____

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AUTHORIZATION FOR VERBAL RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Carole L. Johnson, MD Dermatology to discuss with the following contact concerning 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.

1. _____

2. _____

☐ **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.

Patient or responsible party: _____ Date: _____

NOTICE OF PRIVACY PRACTICES — 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 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	**Signature of Parent or Legal Guardian/Representative**
_____	_____
Printed Name of Patient	**Printed Name of Parent or Legal Guardian/Representative**
_____	_____
Date	**Date**

Documentation of Declining to Sign Acknowledgment:

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 declined to provide a signature when requested.

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MEDICAL & SKIN HISTORY

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____

MEDICAL HISTORY — CHECK ALL THAT APPLY ☐ NONE

☐ Asthma
☐ Autism Spectrum
☐ Blood clot / blood clotting disorder
☐ Cancer (what type?) _____
☐ Diabetes
☐ Hay Fever / Seasonal Allergies
☐ Hepatitis
☐ High blood pressure (hypertension)
☐ HIV/AIDS
☐ Lupus
☐ Mental health issues _____ ☐Other: _____

PAST SURGERIES / PROCEDURES ☐ NONE

☐ Joint Replacement ☐ Heart Valve Replacement ☐ Pacemaker ☐ Organ Transplant

Other surgeries/procedures:

_____

18 or older: Do you require antibiotics before dental cleanings or surgical procedures due to a history of heart valve replacement, joint replacement, and rheumatic/scarlet fever? ☐ YES ☐ NO

SKIN DISEASE / SKIN CANCER HISTORY ☐ NONE

☐ Sensitive Skin ☐ Eczema/Dermatitis ☐ Psoriasis ☐ Acne ☐ Warts

Skin cancer history: ☐ Pre-Cancers ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Melanoma

Family skin cancer history (Mom, Dad, siblings only — not aunts/uncles, etc.):

☐ Melanoma (Relationship): _____

Family skin disease history: ☐ Eczema (Relationship):_____ ☐ Psoriasis (Relationship):_____

MEDICATIONS ☐ NONE

Name, dosage and how many times a day/week taken (if long list please supply a list):_____

_____

_____

MEDICATION ALLERGIES ☐ NONE

_____

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SOCIAL HISTORY, PHARMACY & ADDITIONAL INFORMATION

SOCIAL HISTORY

Tobacco: ☐ Never Smoked ☐ Quit smoking ☐ Smoke now

Alcohol: ☐ NONE ☐ Yes — How many drinks per day? _____

MINOR PATIENT Vaccinations — 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.

ADULT PATIENT ADDITIONAL INFORMATION — COMPLETE IF PATIENT IS 18 OR OLDER

Advanced Directives: Advanced 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: _____

PHARMACY: _____

Address: _____

City: _____ State: _____

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 / Representative Signature: _____ **Date:** _____