Garrott Dermatology
Patient Information

Patient Name:_____ DOB: _____

Reason for Visit: _____

Past Medical History: Please circle all that apply.

Anxiety	Coronary Artery Disease	Hypertension
Arthritis	Depression	Thyroid Disease (High/Low)
Asthma	Diabetes	Leukemia
A. Fib/Irregular Heartbeat	End Stage Renal Disease/CKD	Lung Cancer
Bone Marrow Transplant	GERD (Acid Reflux)	Lymphoma
Benign Prostatic Hypertrophy	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Seizures
Colon Cancer	HIV/AIDs	Stroke
COPD	High Cholesterol	Other:_____

Past Surgical History: Please circle all that apply.

Appendectomy (Appendix Removal)	Liver/Pancreas/Gallbladder *Biopsy* *Removal* *Transplant* *Gallstone Removal*
Breast: Right – Left – Both *Biopsy* *Lumpectomy* *Mastectomy*	Gynecology *Biopsy* *Tubal* *Hysterectomy* *Ovary Removal*
Colon or Rectal Surgery/Resection *Cancer* *Diverticulitis* *Crohn's/UC* *Colostomy*	Skin *Skin Cancer* *Cyst* *Lipoma* *Other*
Heart Surgery *Valve Replacment* *Coronary Artery Bypass* *Stent/Angioplasty* *Transplant*	Testicular Surgery *Biopsy* *Removal* *Vasectomy*
Joint Replacement [Knee, hip, shoulder – L, R, Both]	Other: _____
Kidney/Bladder *Biopsy* *Stones* *Removal* *Transplant*	

Skin Disease History: Please circle all that apply.

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

Do you wear sunscreen? YES or NO – If yes, what SPF? _____
Do you or have you ever used a tanning bed? YES or NO
Do you have a family history of melanoma? YES or NO – If yes, what family member/relative?_____
Please list any other pertinent family history:_____

Do you have a pacemaker?	YES	NO
Do you have a defibrillator?	YES	NO
Do you bleed easily?	YES	NO
Do you have problems with healing?	YES	NO
Do you develop keloids/scars?	YES	NO
FEMALES: Are you pregnant/planning pregnancy?	YES	NO

Medications:

Please list each medication you are currently taking. Please include over the counter medications, vitamins/supplements/herbals. If more than 10 medications, please request additional medications form.

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Allergies:

1.	2.	3.	4.

Do you have an allergy to the following? Please circle if applicable.

LATEX	LIDOCAINE	ADHESIVES

Social History:

Cigarette Smoking	Never smoked	Former Smoker	Less than daily smoker	Daily Smoker
Alcohol Use	None	< 1 drink/day	1-2 drinks/day	3+ drinks/day

Do you have a history of illicit drug use? YES or NO

Do you feel safe at home? YES or NO

PATIENTS OVER 65:

Have you received a pneumonia vaccination? YES or NO

Do you have a health care proxy in the event you are unable to make your own medical decisions? YES or NO

If yes, what is your health care proxy's name and contact number?_____

Do you have a living will? YES or NO

PATIENTS UNDER 18:

Is there anyone in addition to parent/guardian that may accompany patient to appointments?

Name	Relation to patient	Contact Number
1.		
2.		
3.		

LANGUAGE:	English	Spanish	French	Vietnamese	Other:_____
RACE:	Caucasian	African American	Asian	Native American	Hispanic

PREFERRED PHARMACY

Name:_____ City:_____ State:_____

PRIMARY CARE PROVIDER_____ Telephone#:_____

_____ _____

Signature of Patient/Patient's Guardian Date

Garrott Dermatology
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PATIENT INFORMATION

Name: _____

Social Security #: _____DOB: _____ Sex:_____ Marital Status: _____

Address: _____City: _____State: _____ Zip: _____

Cell Phone _____ Home Phone _____Email: _____

Employer _____ Occupation _____ Work Phone _____

RESPONSIBLE PARTY [IF OTHER THAN PATIENT]: (Please provide photo ID to receptionist)

COMPLETE THIS SECTION IF PATIENT IS UNDER 18 OR SOMEONE OTHER THAN PATIENT IS LEGALLY RESPONSIBLE

Legal Guardian _____ Telephone Number _____

Social Security #: _____ DOB_____Relationship to Patient _____

Mailing Address (if different from patient) _____

City_____ State _____ ZIP _____

INSURANCE INFORMATION

PLEASE PRESENT PHOTO ID & INSURANCE CARD(S) TO RECEPTIONIST*

Primary Insurance Carrier _____Policy Number_____ Group Number _____

Policyholder's Name_____ Policyholder's DOB:_____

Secondary Insurance Carrier _____Policy Number_____ Group Number _____

Policyholder's Name_____ Policyholder's DOB:_____

PERMISSION TO GIVE MEDICAL INFORMATION

Do you give permission for us to leave a voicemail regarding appointments, pathology, test results? YES or NO

If yes, please provide the contact number to leave a voicemail. _____

I hereby authorize the providers and staff of Garrott Dermatology to give information concerning my health and wellbeing to the person(s) listed below including appointment times, test/lab results, prescription refills, procedures, and any other information regarding my health:

Name:_____Relationship: _____Telephone Number:_____

Name:_____Relationship: _____Telephone Number:_____

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

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. AT THE TIME OF SERVICES RENDERED, PAYMENT IS EXPECTED FROM YOU FOR YOUR RESPONSIBLE CHARGES (CO-PAY, DEDUCTIBLE). WE ACCEPT ALL MAJOR CREDIT CARDS (INCLUDING CARE CREDIT. 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 fe es, 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 Provider when assigned claim is filed.

SIGNATURE (Patient/Responsible Party):_____DATE:_____

NOTIFY OF PRIVACY PRACTICES

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

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
24 Marks Road – Ocean Springs, MS 39564
Telephone: (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 revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and we may decline to treat/continue treating you if you revoke this Consent.

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

SIGNATURE (Patient/Responsible Party):_____DATE:_____