3400 Ross Clark Circle
Dothan, AL 36303

WIREGRASS DERMATOLOGY

Phone (334) 679-7974
Fax (334) 305-2199
WiregrassDermAL@gmail.com

Patient Information

Patient Full Name: _____ Date of Birth: _____ Age:_____

Preferred Name: _____ Email: _____

SSN: _____ Birth Sex: _____ Gender Identity: _____

Marital Status: ☐ Married, ☐ Single, ☐ Divorced, ☐ Widow

Primary Mailing Address: _____ Apt/Suite # _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Primary Care Provider: _____ Occupation/Employer: _____

Pharmacy Name, Address & Phone #: _____

Emergency Contact Information

Name: _____ Relationship: _____ Contact Number: _____

Insurance Information

Primary Insurance Company: _____ Policy ID Number: _____

Policy Holder's Name: _____ Relationship to patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Employer: _____

Secondary Insurance Company: _____ Policy ID Number: _____

Policy Holder's Name: _____ Relationship to patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Employer: _____

Acknowledgement of Financial Agreement/Responsibility

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. I understand that I am responsible for making sure Wiregrass Dermatology (and its providers) are in network with my insurance company and that my insurance company doesn't require a referral before being seen by a specialist. 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's Signature: _____ **Date**: _____

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Authorization for Verbal release of Protected Health Information

STANDARD Disclosure

I authorize Wiregrass 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

Name: _____ Relationship: _____

☐ **No information**
I do not authorize release of any verbal information concerning my treatment. I understand that this includes confirmation of appointment dates, times, location, and any billing or financial information.

☐ **I consent and authorize the release of any test results to be left on my voicemail at**
Home _____ Cell Phone _____

This authorization will expire at the end of my treatment with Wiregrass Dermatology unless I revoke the consent prior to that time.

Acknowledgement of Privacy Practices

I understand that under the HIPAA (Health Insurance Portability and Accountability Act of 1996), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing this form, I acknowledge receiving and understanding the Privacy Practices of Wiregrass Dermatology.

Consent to ePrescribe

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.

Consent to Photograph

The undersigned hereby authorizes Dr. Andrea Alexander, Rachel B. Gilbert, PA-C, Sydney Givens, PA-C and their staff to photograph pertinent lesions or rashes that would assist in my dermatologic care.

While under the care of Dr. Andrea Alexander, Rachel B. Gilbert, PA-C, or Sydney Givens, PA-C of Wiregrass Dermatology, I agree that they may use these photos for clinical purposes and documentation in my chart. These photos may be shared with their colleagues as deemed necessary for my patient care.

Name of Patient _____ Date of Birth _____

Signature of Patient or Legal Guardian _____ Date _____

Signature of Witness _____ Date _____

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Check the **Skin & Medical Conditions** that *YOU* currently have or had before:

- ☐ Atopic Dermatitis (Eczema)
- ☐ Seasonal Allergies
- ☐ Asthma
- ☐ Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Fever Blisters (Herpes)
- ☐ Skin Cancer
  - **Basal**. *Body Location*_____ *MM/YY* _____
  - **Squamous**. *Body Location*_____ *MM/YY* _____
  - **Melanoma**. *Body Location*_____ *MM/YY* _____
- ☐ Dysplastic Nevus of Skin (Abnormal Mole)
  *Body Location*_____ *MM/YY* _____
- ☐ Lupus
- ☐ (+) PPD test (Tuberculosis)
- ☐ Liver Disease
- ☐ Hepatitis (circle: A, B or C)
- ☐ HIV/AIDS
- ☐ Organ Transplant
- ☐ High Blood Pressure
- ☐ Diabetes (Type 1 or 2)
- ☐ Kidney Disease/failure
- ☐ Anxiety
- ☐ Depression
- ☐ Hypothyroidism

Any Other Medical Conditions or Cancer History (not listed above): _____

_____

Have you ever had surgery? ☐ **No** ☐ **Yes**, list Year and Type of Surgery: _____

_____

Medications:

Medication Name	Dosage	Frequency	Why do you take it?

Have any of your family members had Melanoma?

- ☐ NO
- ☐ YES. Which family member?

  _____

  If YES, Where?

  _____

Smoking status:

- ☐ Never
- ☐ Former Smoker
- ☐ Current Smoker. # Packs per day: _____

Allergies/Reactions to medications or food?

- ☐ NO
- ☐ YES _____

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Check the symptoms you currently have:

General:
- ☐ Fever
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Unexplained Weight Loss

Eyes:
- ☐ Dryness
- ☐ Change in vision
- ☐ Irritation

Ears, Nose, Throat:
- ☐ Dry Mouth
- ☐ Sore Throat
- ☐ Fever Blisters

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations

Respiratory:
- ☐ Shortness of breath
- ☐ Cough

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Diarrhea

Genitourinary:
- ☐ Pain with urination
- ☐ Frequency of urination

Musculoskeletal:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle aches

Skin:
- ☐ Rash
- ☐ Itching
- ☐ Changing lesion
- ☐ Skin bumps
- ☐ Suspicious lesion
- ☐ Keloid

Neurologic:
- ☐ Seizures
- ☐ Loss of strength
- ☐ Loss of sensation
- ☐ Headaches

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Change in mood

Endocrine:
- ☐ Hair changes
- ☐ Increased sweating

Heme/Onc:
- ☐ Easy bruising
- ☐ Enlarged Lymph nodes

Immunologic:
- ☐ Hives
- ☐ Seasonal Allergies
- ☐ Immunosuppression

Do you take **Aspirin or a blood thinner**? ☐ **No** ☐ **Yes** _____

Females: Are you pregnant?
- ☐ NO
- ☐ YES. How many weeks? _____
- ☐ Trying to get pregnant.
- ☐ Breastfeeding

Complete this box if you are age 65 and above:

Pneumonia Vaccine: ☐ **No** ☐ **Yes**

Healthcare Proxy's Name _____ Phone Number_____
(Person/Family member that can make medical decisions for you if you are unable)

Do you have a Living Will or Advanced Care Directive: ☐ **No** ☐ **Yes**
(please **check one** of the following)
- ☐ Full Code – Patient wishes to have full cardiopulmonary resuscitation efforts to be made
- ☐ Do Not Intubate – Patient does NOT wish to have a breathing tube, even if it is required for life saving measures
- ☐ Do Not Resuscitate (DNR) – In the event that the patient's heart was to stop, the patient does NOT wish to have chest compressions or an automated external defibrillator to restart the heart, even if it is required for life saving measures.

Signature of Patient or Legal Guardian _____ **Date** _____