GIBSON DERMATOLOGY

PATIENT INFORMATION

PRIMARY PHYSICIAN _____
First Name _____ MI _____ Last Name _____
Address _____
City _____ State _____ Zip_____ Telephone _____
Email _____
DOB _____ Sex _____ Marital Status S M W D SSN _____
Employer _____ Employer Telephone _____
Employer Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN THE PATIENT)

First Name _____ MI _____ Last Name _____
Address _____ Telephone _____
City _____ State _____ Zip _____
DOB _____ Sex _____ Marital Status S M W D SSN _____
Employer _____ Employer Telephone _____
Employer Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance Co _____ Effective Date _____
Address _____ Telephone _____
City _____ State _____ Zip _____
Group # _____ Policy/ID # _____
Insured's Name _____ Relationship to Patient _____
Insured's DOB _____ Insured's SSN _____
Insured's Employer _____
Insured's Address _____
Insured's Telephone _____ Copay Amount _____

Secondary Insurance Co _____ Effective Date _____
Address_____ Telephone _____
City _____ State _____ Zip _____
Group # _____ Policy/ID# _____
Insured's Name _____ Relationship to Patient _____
Insured's DOB _____ Insured's SSN _____
Insured's Employer _____
Insured's Address _____ Insured's Telephone _____

****EMERGENCY** Please give the name and telephone number of a friend or relative that *DOES NOT* live at your address**

Name _____ Telephone _____

ALL SERVICES RENDERED ARE THE FINANCIAL RESONSBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR FINANCIAL RESPONSIBILITY IS TO ENSURE GIBSON DERMATOLOGY IS PAID FOR SERVICE RENDERED. THIS INCLUDES LIABILITY COVERED INJURIES, AS BILLS WILL NOT BE POSTPONED IN ANTICIPATION OF LEGAL SETTLEMENT. INFORMATION WILL BE PROVIDED TO YOU TO FILE YOUR OWN INSURANCE AND SUPPLIED TO YOUR ATTORNEY UPON REQUEST.

I HEREBY AUTHORIZE GIBSON DERMATOLOGY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO GIBSON DERMATOLOGY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFECT FOR AS LONG AS MY DEPENDENT OR I REMAIN A PATIENT.

_____ _____
Signature of Patient or Guardian Date

PATIENT MEDICAL INFORMATION

Name _____ Date _____

PRESENT/PAST MEDICAL HISTORY
Please check any you have had or have at the present time

___ Heart disease
___ Heart failure
___ Heart murmur
___ Heart pacemaker
___ Heart defibrillator
___ Artificial heart valve
___ Mitral valve prolapse
___ Heart surgery
___ Congenital heart lesion
___ Rheumatic fever
___ High blood pressure
___ Tuberculosis
___ HIV infection/AIDS
___ Sexually Transmitted Disease
___ Deep fungal infection
___ Hepatitis
___ Liver disease
___ Kidney disease
___ Thyroid disease
___ Lupus
___ Sinus trouble
___ Depression
___ Glaucoma
___ Asthma
___ Anemia
___ Sickle Cell Anemia
___ Hemophilia
___ Bleeding problems
___ Bruise easily
___ Healing problems
___ Keloids
___ Hives
___ Arthritis
___ Artificial joint
___ Diabetes
___ Stomach/duodenal ulcer
___ Cancer/Malignancy
___ Other (please list) _____
_____

SURGICAL HISTORY _____
_____

DRUG ALLERGIES (Please mark and list type of reaction)

___ Penicillin _____
___ Codeine _____
___ Lidocaine/Xylocaine _____
___ Erythromycin _____
___ Aspirin _____
___ Sulfa _____
___ Novacain _____
___ Tetracycline _____
___ Other _____

NON-DRUG ALLERGIES and REACTION (e.g., latex, tape allergy, food allergy)
_____
_____
_____
_____

CURRENT MEDICATIONS (Including all prescriptions, non-prescription items, supplements, etc. If none, please note)
_____
_____
_____

DO YOU REQUIRE PRE-MEDICATION PRIOR TO SURGERY DUE TO ARTIFICIAL JOINTS AND/OR HEART VALVES?

___ Yes ___ No List Drug_____

PATIENT MEDICAL INFORMATION

SOCIAL HISTORY

Do you smoke? ___ No ___ Yes Frequency _____
Do you drink alcohol? ___ No ___ Yes Frequency _____

REVIEW OF SYSTEMS
Please check any symptoms you are currently experiencing

___ Fever	___ Chills	___ Weight Loss
___ Hair Loss	___ Irritated/Inflamed eyes	___ Sinusitis
___ Gum disease	___ Chronic mouth sores	___ Asthma
___ Stomach ulcer	___ Diarrhea	___ Genital sore
___ Arthritis	___ Leg swelling (Edema)	___ Joint swelling
___ Itching (Pruritis)	___ Anemia	___ Seizures
___Thyroid disorder	___ Excessive bleeding	___ Blood clots
___ Bruise easily	___ Excessive hair on face/body	___ Fever blisters

___ Other _____

MALES ONLY: ___ Prostate problems
FEMALES ONLY: ___ Currently taking oral contraceptives
___ Currently pregnant, could possibly be pregnant, trying to become pregnant

FAMILY HISTORY
Check any that are pertinent to your family

___ Skin cancer	___ Melanoma	___ Asthma	___ Diabetes	___ Arthritis
___ Bleeding tendency	___ Thyroid disease	___ Internal Cancer	___ Hepatitis	___ Kidney disease

DOCTOR'S NOTES ON ABOVE HISTORY AND REVIEW OF SYSTEMS

_____
_____
_____

I have completed this form to the best of my ability. If I have a change of health, I will notify you at my next appointment.

_____ _____
PATIENT SIGNATURE DATE

THANK YOU FOR COMPLETING THIS FORM. THIS WILL ALLOW US TO EVALUATE YOUR SKIN CONDITION MORE COMPLETELY.

I HAVE REVIEWED THIS PATIENT INFORMATION FORM:

_____ _____
PHYSICIAN'S SIGNATURE DATE

GIBSON DERMATOLOGY

Gunnar H. Gibson, MD Jacey T. Guthrie, MD
Rebecca Lard, APN

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Gibson Dermatology Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services.

SIGNATURE _____ DATE _____

If you are not the patient, please fill out the following information:

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

_____

TELEPHONE: _____

People allowed access to my medical records:

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

PRIOR AUTHORIZATIONS

Some insurance companies are requiring prior authorization before filling prescriptions for medications. In all cases our staff is required to call the insurance company and provide information about the patient's condition. The range of questioning runs from simple to very complex and time consuming. Due to the time involved, we must ask that you help. If you as an insured can bypass the prior authorization the problem would be solved. If we must spend time on the process, we will have to pass the cost along to you. This process will result in a $25.00 reporting fee.

Please contact your insurance company and ask them to discontinue or simplify the prior authorization process. You pay for the insurance and deserve better.

Sincerely,

Dr. Gibson and Staff

_____ _____

SIGNATURE OF PATIENT or LEGAL GUARDIAN FOR PATIENT DATE

_____

PRINTED NAME OF PATIENT OR LEGAL GUARDIAN FOR PATIENT

HELP US HELP YOU!!

WHAT IS THE NAME OF YOUR PHARMACY?

WHAT IS THE TELEPHONE?

MISSED APPOINTMENT POLICY

Appointments not cancelled at least 24 hours in advance will be assessed a minimum charge of $20.00. Charge must be paid before next appointment date.

Thank you for your cooperation

PATIENT SIGNATURE _____ DATE_____