GIBSON DERMATOLOGY

Gunnar H. Gibson, MD Jacey T. Guthrie, MD

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____
Address _____ Telephone _____ Cell _____
City _____ State _____ Zip _____
DOB _____ Sex _____ Marital Status **S M W D** SSN _____
Email _____
Employer _____ Employer Telephone _____
Employer Address _____ City _____ State _____ Zip _____
Primary care Physician _____ **Telephone** _____

RESPONSIBLE PARTY INFORMATION (if other than the patient)

First Name _____ M.I. _____ 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 between Patient and Policy Holder _____
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 Between Patient and Policy Holder _____
Insured's DOB _____ Insured's SSN _____ Insured's Employer _____
Insured's Address _____ Insured's Telephone _____

EMERGENCY CONTACT: 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 RESPONSIBILITY 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 SETTLEMEMT. INFORMATION WILL BE PROVIDED TO YOU TO FILE YOUR OWN INSURANCE AND SUPPLIED TO YOUR ATTORNEY UPON REQUEST.

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

X _____ **DATE** _____

(SIGNATURE OF PATIENT OR GUARDIAN)

Please place a check mark next to any ALLERGY/CONDITION that applies:

- ☐ Pregnant
- ☐ Latex allergy
- ☐ Heart defibrillator
- ☐ Hepatitis
- ☐ HIV/Aids
- ☐ Melanoma
- ☐ Penicillin
- ☐ Sulfa
- ☐ Lidocaine / Xylocaine
- ☐ None

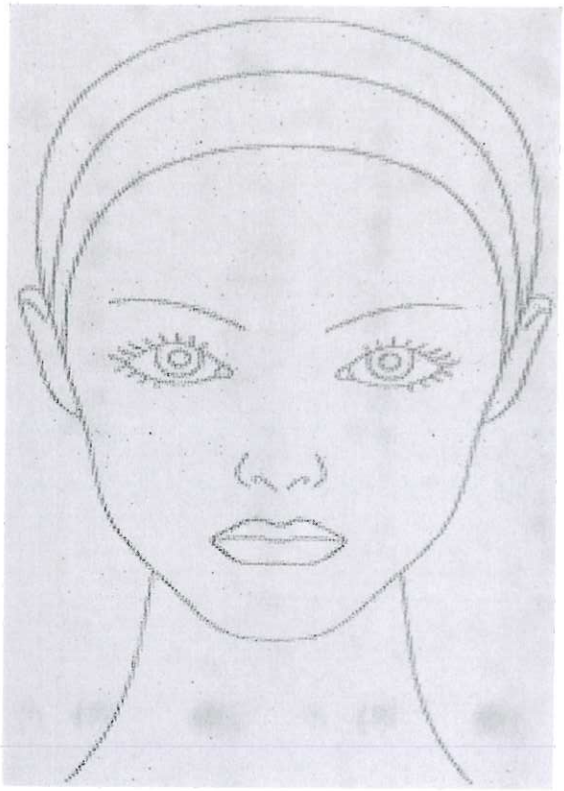
Print Name _____

COSMETIC INTEREST QUESTIONAIRE

PLEASE COMPLETE THIS FORM ***ONLY*** IF YOU ARE INTERESTED IN LEARNING ABOUT SKINCARE OR OTHER COSMETIC SERVICES

Other than the reason for your appointment today, what additional skin care services or procedures would you like to learn about? Please check all that apply:

- o Skin care advice
- o Skin care products
- o Sunscreen
- o Facial injectables such as Botox/Disport or Fillers
- o Chemical peels
- o Microneedling
- o Laser correction for redness or visible blood vessels
- o Cosmetic mole, age spots, or skin tag removal
- o Leg vein correction
- o Acne scars
- o Hyperhidrosis (increased sweating)



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: (Circle if any apply & list type of reaction)

____Penicillin_____ ____ Aspirin_____
____Codeine_____ ____ Sulfa_____
____Lidocaine/Xylocaine_____ ____ Novocain_____
____Erythromycin_____ ____ Tetracycline_____
____Other_____

NON-DRUG ALLERGIES: (ex. Latex, tape allergy, food allergy. Include your type of reaction).

_____

_____

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 OR HEART VALVES? YES ___ NO ___ LIST DRUG _____

SOCIAL HISTORY

DO YOU SMOKE? NO____ YES_____ FREQUENCY_____
DO YOU DRINK ALCOHOL? NO_____ YES_____ FREQUENCY_____

REVIEW OF SYSTEMS: (check 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 sores
____ Arthritis	____ Leg swelling (edema)	____ Joint swelling
____ Itching (pruritus)	____ Loss of pigment of skin	____ Seizures
____ Thyroid disorder	____ Anemia	____ Blood clots
____ Bruise easily	____ Excessive bleeding	____ Fever blisters
____ Seasonal allergies	____ Excessive hair on face/body	

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

DOCTOR'S NOTES ON ABOVE HISTORY & 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 MEDICAL INFORMATION FORM:

_____ _____
PHYSICIAN'S SIGNATURE DATE

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ACKNOWLEDGEMENT 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_____

NAME_____ DOB_____

NAME_____ DOB_____

ADMINISTRATION FEES

Starting October 1, 2020, our clinic will be charging a $25 administration fee to fill out any insurance, legal, FMLA or other medical forms outside of routine paperwork.

SIGNATURE OF PATIENT or LEGAL GUARDIAN FOR PATIENT _____ DATE _____

MISSED APPOINTMENT POLICY

Appointments not canceled at least 24 hours in advance will be assessed a minimum charge as listed below:

- 1st NO SHOW will be a charge of $30.00.
- 2nd NO SHOW will be a charge of $50.00.
- 3rd NO SHOW will be a charge of $75.00 and will need approval from your Doctor before rescheduling

***Charges must be paid before next appointment will be scheduled. ***

Thank you for your cooperation!

PATIENT SIGNATURE_____ **DATE**_____

HELP US HELP YOU!!

WHAT IS THE NAME OF YOUR PHARMACY?

_____

PHONE_____

ADDRESS (IF KNOW) _____