615 1st Street, North, Alabaster
450 A Century Park S Ste 200, Birmingham
1320 Woodfin Lane, Clanton
1205 County Rd. Cullman
Phone: (205) 624-2100
Fax: (205) 624-2104
www.truedermatology.com

Patient Information

Last Name		First		Middle	
Date of Birth	Age	Sex M / F	Race	Social Security Number	
Billing Address		City		State	Zip Code
Home Phone #		Cell Phone #		Work Phone #	
Email Address		Occupation		Employer	
Marital Status Single Married Divorced Widowed		Primary Physician			
Emergency Contact		Emergency Contact's Phone #			
☐ I give my consent to discuss my medical information with my emergency contact					

Consent for Treatment – I consent to necessary treatment including medications, procedures, or other studies that may be used by the physician, nurse practitioner, or staff.

Authorization for Release of Information – I authorize True Dermatology LLC to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

Assignment of Benefits – I hereby authorize payment directly to True Dermatology LLC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible to True Dermatology LLC. for charges not covered by this assignment.

Communication Regarding My Account – Until my account is settled, I give direct consent to receive communications regarding my account from any services and any collectors of my account through various means such as:

1) cell, landline, or text numbers that I provide; 2) any email address that I provide; 3) auto dialer systems; 4) voicemail messages and other forms of communications.

Guarantee of Account – For services furnished by True Dermatology LLC, I hereby guarantee the payment of all accounts for services rendered within 90 days. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection including attorney's fees.

If an outside laboratory is used, I understand that I am financially responsible for any separate bills from that facility.

Signature: ______________________________ **Date:** ______________

TRUE DERMATOLOGY
Skin Cancer Surgery & Medical Specialists

Patient Name: ____ **Date of Birth:** ____________

Primary Care Provider: ____ **Height:** _________ **Weight:** _______

Past Medical History: (Please circle ALL that apply)		
Anxiety	Depression	Thyroid Problems
Arthritis	Diabetes	Leukemia
Asthma	ESRD	Lung Cancer
Atrial Fibrillation	GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Therapy
Colon Cancer	High Blood Pressure	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery Disease	High Cholesterol	None
Any other conditions not listed:		

Pertinent Past Surgical History: (Please circle all that apply)	
Heart Valve Replacement	Hysterectomy
Organ Transplant: Heart, Liver, Kidney, Lung	Joint Replacement (in last 2 years)
Ovaries Removed	None
Any other surgeries not listed:	

Skin Disease History: (Circle ALL that apply)	
Acne	Eczema
Actinic Keratosis	Itchy Scalp
Basal Cell Cancer	Melanoma (If so, when?) ________
Blistering Sunburns	Psoriasis
Dysplastic Nevus	Seasonal Allergies
Dry Skin	Squamous Cell Cancer
Other:	

Sun Protection: (Circle Yes or No)

Do you wear sunscreen? Yes No

Have you used a tanning bed? Yes No

Do you have family history of Melanoma?

Yes No

If so, which relative? _______________

Pharmacy Name: ____ Phone #: ______________________

Pharmacy Address: ____

Medication Allergies (if none, please write "NKDA") : ____

Do you consent to have medications imported from your pharmacy? *Yes* *No*

(*If NO, please see receptionist for additional paperwork)

Do you take any of the following blood thinners? (Please circle ALL that apply)			
Eliquis	Plavix	Xarelto	Pradaxa
Coumadin	Aspirin	Heparin	Other:

Do you have a living will/advanced directive? *Yes* *No*

Have you received your *flu* vaccine? *Yes* *No*

Have you received your *pneumonia* vaccine? *Yes* *No*

Alcohol Intake:	**Smoking Status:**
None	Current everyday smoker
Less than 1 drink per day	Current someday smoker
2- 3 per day	Former smoker
3 or more per day	Never Smoker

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PLEASE SIGN WHERE INDICATED BELOW

Please read the following statement carefully and sign below

All of the information that I have provided on this form is true and complete. The signature below will also be used as a "signature on file" for insurance purposes including any medical information necessary to process relevant claims. I hereby assign my insurance benefits to be paid directly to True Dermatology, LLC. I am aware it is my responsibility to obtain a referral if one is required by my insurance. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I certify that the insurance information I have provided above is accurate and that the coverage I have listed above is currently active and not expired. I give my permission for photographs to be taken for diagnostic purposes and to enhance medical records, and I agree that these photographs may be used for medical, scientific, educational or marketing purposes provided that they do not include any information or content that could reveal my identity. (Please cross out the previous sentence if not desired.) I hereby authorize Raj Patel M.D., and the staff at True Dermatology, LLC. to administer any treatment or to administer such anesthetics and to perform such procedures as may be deemed necessary or advisable for my diagnosis and treatment. I have read the True Dermatology, LLC. Financial Policy Statement along with the credit card policy and agree that I am ultimately responsible for all non-covered services.

Printed Name (First, Middle, Last):

____

Signature:____ Date:_____/_____/

For Medicare Patients: I hereby authorize medical benefits to True Dermatology, LLC

Printed Name (First, Middle, Last):

____

Signature: ____ Date:_____/_____/

TRUE DERMATOLOGY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the new Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement,if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Printed Name *(First, Middle, Last)*: ______________________________________

Signature: ____ Date: ____/____/____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ **The patient refused to sign.**
- ☐ **Due to an emergency situation it was not possible to obtain an acknowledgement.**
- ☐ **We weren't able to communicate with the patient.**
- ☐ **Other (Please provide specific details)**

____

Staff Signature ____ Date__________