PLEASE PRINT

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Southern Skies
Dermatology & Surgery

St. Vincent's East Campus
48 Medical Park Drive E Suite #458,
Birmingham, AL 35235

Phone: (205) 900-2000

St. Vincent's St. Clair Outpatient Clinic
7063 Veterans Pkwy
Pell City, AL 35125

Fax: (205) 838-4525

Gadsden Regional Medical Center
300 Medical Center Drive Suite #402
Gadsden, AL 35903

www.southernskiesdermatology.com

Patient Payment Information

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

PATIENT'S FULL NAME	SOC. SEC. NO.	SEX M	SEX F	DATE OF BIRTH / /	AGE
MAILING ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE		CELL PHONE	
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) ☐ PART TIME ☐ FULL TIME	MARITAL STATUS S	M	W	D / SEP
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE	BUSINESS PHONE			
SPOUSE'S OR PARENT'S NAME	SOC. SEC.NO.	DATE OF BIRTH / /		CELL PHONE	
SPOUSE'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) ☐ PART TIME ☐ FULL TIME	BUSINESS PHONE			
PATIENT EMAIL ADDRESS					

RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY	SOC. SEC. NO.	DATE OF BIRTH	HOME PHONE	CELL/WORK PHONE
MAILING ADDRESS	CITY, STATE, ZIP CODE	RELATIONSHIP TO PATIENT		
RESPONSIBLE PARTY'S EMPLOYER	CITY, STATE OF EMPLOYER	BUSINESS PHONE		

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO.	CO-PAY	CONTRACT NO.	GROUP NO.	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) DATE OF BIRTH	
NAME OF SECONDARY INSURANCE CO.	CO-PAY	CONTRACT NO.	GROUP NO.	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) DATE OF BIRTH	
ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE? YES	NO	IF YES: NAME OF INSURANCE CO.		CONTRACT NO.	GROUP NO.

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

NAME	HOME PHONE	CELL/WORK PHONE	RELATIONSHIP
MAILING ADDRESS	CITY, STATE, ZIP CODE		

EXPLANATION OF PAYMENT POLICY, INSURANCE FILING PROCEDURES, AND FINANCIAL RESPONSIBILITY AGREEMENT

I hereby authorize Southern Skies Dermatology and Surgery to release any and all information acquired in my examination and treatment to my insurer listed above. If I am covered by Blue Cross, Medicare and/or Medicaid, I will furnish my insurance card and signature. If I am covered by other insurance, I will furnish the necessary forms to this office.

I hereby assign and authorize payment directly to Southern Skies Dermatology and Surgery any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference.

I understand that payment is due at the time of service. I agree to pay collection fees of 33 1/3 % of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney's fees of 33 1/3% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment.

I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers to contact me regarding my care and my account by this medical provider and this medical provider's business associates.

I authorize treatment by Southern Skies Dermatology and Surgery Physicians and personnel.

Patient/Guardian _____ Signature Date _____

I certify that all information on this form is correct to the best of my knowledge. Recertify.

Signature:_____ Date:_____

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SYSTEMS REVIEW-PERSONAL/FAMILY HISTORY

DATE	PATIENT NAME	PATIENT DOB

ALERTS (PLEASE CIRCLE ALL THAT APPLY)

Hepatitis C Positive
HIV Positive
Allergy to adhesive
Allergy to lidocaine
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedure

MEDICATION ALLERGIES (PLEASE CIRCLE ALL THAT APPLY)

Aspirin
Sulfa Drugs
Penicillin
Erythromycin
Codeine
Tetracycline
Morphine
Keflex (Cephalosporin)
None
Other_____

ALLERGIC/ IMMUNOLOGIC (CIRCLE)
Food, Insect, Jewelry
Ointments, Creams, Lotions, Cosmetics
Hay Fever, Asthma, Sinus, Eyes
Other_____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY FORM OF CANCER? (CIRCLE)
Skin Cancer
Melanoma
Other_____

HAVE YOU BEEN HOSPITALIZED DURING THE PAST 3 YEARS? YES NO
For What Condition?_____

CARDIOVASCULAR (CIRCLE)
Blood Pressure
Heart Attack
Irregular Heartbeat
Are You Presently Taking Blood Thinners?
If Yes, What Type?
( ) Coumadin ( ) Aspirin ( ) Plavix
( ) Ticlid ( )Persantine [Dipyridamole]
( ) Other_____
Enlarged Heart (Heart Failure)
Chest Pain
Easy Bleeding

RESPIRATORY (CIRCLE)
Asthma
Emphysema

GASTROINTESTINAL (CIRCLE)
Ulcer Disease
Colitis or Inflammatory Bowel Disease

Signature_____

Date_____

GENITOURINARY
Kidney Failure

FEMALE ISSUES (CIRCLE)
Miscarriage
Pregnancy
Are You Currently Using Birth Control Pills?

MUSCULOSKELETAL
Arthritis

NEUROLOGICAL (CIRCLE)
Seizure
Stroke or Paralysis
Tendency to Faint

MENTAL STATUS (CIRCLE)
Tendency Toward Nerves
Tendency Toward Depression

ENDOCRINE (CIRCLE)
Thyroid Disease
Diabetes

HEMATOLOGICAL (CIRCLE)
Anemia
Bleeding or Clotting Disorder

SOCIAL HISTORY
Do You Smoke Presently? Yes No How much?_____
Do You Consume Alcoholic Beverages? Yes No How Much?_____

FAMILY HISTORY (CIRCLE)
Do Any Immediate (blood) Relatives Have Any Of The Following? Do Not Consider Yourself.

Hay Fever
Drug Allergy
Diabetes
Heart Disease
Bleeding Disorders
Psoriasis
Eczema
Skin Problems
Skin Cancer
Skin Melanoma

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DATE	MEDICATION	DISCONTINUED

List all medicines, even if you only take them occasionally: Please include laxatives, tranquilizers, sleeping pills, antihistamines, vitamins, aspirin, pain pills, blood thinners, birth control pills, blood pressure pills, fluid pills, etc.

PREFERRED PHARMACY:_____ **PHONE #:**_____

At the time of each visit, the medical information was reviewed and corrected where appropriate.

DATE	STAFF INIT.	M.D. INIT.	DATE	STAFF INIT.	M.D. INIT.

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Southern Skies Dermatology and Surgery may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Southern Skies Dermatology and Surgery Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Southern Skies Dermatology and Surgery reserves the right to revise its Notices of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by request to Southern Skies Dermatology and Surgery.

With my consent, Southern Skies Dermatology and Surgery may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including but not limited to laboratory results.

With my consent, Southern Skies Dermatology and Surgery may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as laboratory and pathology results, appointment reminder cards and patient statements.
With my consent, Southern Skies Dermatology and Surgery may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Southern Skies Dermatology and Surgery restrict how it uses or discloses my PHI to carry out its clinical care. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

During the course of your medical treatment, we strive to communicate with you, the patient; in a timely and professional manner. There are certain occasions when family members, friends, or others might be involved in your care and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please indicate below the names of any other people with whom we can discuss your care and personal health information:

Name:_____ DOB_____Relationship_____

Name:_____ DOB_____Relationship_____

Name:_____ DOB_____Relationship_____

By signing this form, I am consenting to Southern Skies Dermatology and Surgery's use and disclosure of my PHi to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign his consent, Southern Skies Dermatology and Surgery may decline to provide treatment to me.

Signature of Patient/Legal Guardian:_____Date:_____

Relationship to Patient if Legal Guardian:_____