1002 Williamsburg Way

Evans, GA 30809

Phone: (706) 922-3376

Fax: (706) 922-5643

www.evansderm.net

**Patient Health Questionnaire**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_\_/\_\_\_/\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber (circle one) Self Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber D.O.B.:\_\_\_\_/\_\_\_\_/\_\_\_\_\_

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber (circle one) Self Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber D.O.B:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**Reason for today’s visit:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:**

Are you currently taking any medications? (circle one) No Yes

If yes, list medications you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** (check all that apply)

( ) Lidocaine ( ) Epinephrine ( ) Latex ( ) Medication

List medication allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

Do you or have you had any of the following?

( ) Tendency to bleed ( ) Blood clot in lung ( ) Diabetes ( ) Seizures

( ) High/Low Thyroid ( ) Blood clot in leg ( ) Heart Murmur ( ) Asthma

( ) Heart Disease ( ) Mitral valve prolapse ( ) Stroke ( ) Lupus

( ) Rheumatic fever ( ) Blood transfusion ( ) Kidney disease ( ) Hepatitis

( ) Hay fever/Allergies ( ) Rheumatoid arthritis ( ) Tuberculosis ( ) HIV/AIDS

( ) Radiation therapy ( ) High blood pressure ( ) Depression

( ) Heart attack ( ) Organ Transplant ( ) Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Bleeding post dental ( ) Bleeding post-surgery

( ) Other medical conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE PATIENTS ONLY:** (circle one)

Are you pregnant? No Yes Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you breastfeeding? No Yes

**SURGICAL HISTORY:** (check all that apply)

( ) Internal Defibrillator ( ) Pacemaker ( ) Heart Valve Replacement

( ) Heart Bypass Surgery ( ) Joint Replacement

( ) Dermatologic Surgery Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DERMATOLOGIC HISTORY:**

Please rate your skin type

( ) Type I – Always burns, never tan ( ) Type II – Always burns, sometimes tan

( ) Type III – Sometimes burns, always tan ( ) Type IV – Never burns, always tans

( ) Type V – Never burns, tans moderate

Have you ever had abnormal scarring? No Yes

Have you ever been diagnosed with a skin disorder? No Yes

If yes, list skin disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a pre-cancer? No Yes

If yes, list pre-cancer type/location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had abnormally pigmented lesions or moles? No Yes

Have you ever had a skin cancer? No Yes

(Basal cell, Squamous Cell, Melanoma?)

If yes, list type and location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you treated for skin cancer? No Yes

If yes, what was your treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:** (please circle and provide details as needed)

Do you or have you used alcohol? No Yes

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Quit\_\_\_\_\_

Do you or have you used tobacco? No Yes

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Quit\_\_\_\_\_

Do you or have you used illegal drugs? No Yes

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Quit\_\_\_\_\_

**RISK FACTORS:**

Have you ever spent long hours in the sun for work
or other activities? No Yes

Do you tend to burn or freckle easily? No Yes

Do you use sunscreen daily? No Yes

Do you have an outdoor occupation or hobby? No Yes

Have you ever had an x-ray treatment for a skin disorder? No Yes

Is there a history of Melanoma in first degree relatives? No Yes

 (mother, father, brother or sister)

If yes, relationship and type of Melanoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you previously used tanning beds? (circle one) No Yes

If yes, how many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Quit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL RECORDS POLICY:**

Your medical record is the property of Evans Dermatology. We will send all pertinent information to any doctor to whom we refer you at no charge. If you move or transfer your care to another dermatologist, we will also forward records at no charge. However, there will be a charge for any other request for medical records as allowed by Georgia Law. This includes completion of forms for insurance companies for Life Insurance, Disability Insurance, Cancer Policies, etc. \_\_\_\_\_\_\_\_\_\_initial

**INSURANCE POLICY:**

**PLEASE UNDERSTAND THAT YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU (THE PATIENT) ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF YOUR MEDICAL BILLS. WE CAN ONLY ASSIST YOU IN OBTAINING SPECIFIED CONTRACT BENEFITS. FILING INSURANCE IS A SERVICE THAT WE PROVIDE AS A COURTESY TO YOU.**

* **CO-PAYS:** Co-pays are a way insurance companies have of sharing the cost of your healthcare with you, the patient. Every time you come to our office for a Specialist medical visit, you will be expected to pay your co-pay. No exceptions will be made. If you have a condition requiring frequent visits or follow up visits to our office, expect to make a co-pay each visit. Your co-pay may not/will not cover the entire cost of your office visit and/or any procedures you may have done. (Office visit charges do not include procedure charges, you will be billed separately for each). We will submit all charges for your office visit and procedures to your insurance company. Your insurance company determines what portion of your office visit and/or procedure cost, exceeding your co-pay, that you will be responsible for. \_\_\_\_\_\_\_\_\_\_initial
* **DEDUCTIBLES:** Most insurance plans have a deductible. A deductible is an amount of money your insurance company expects you to pay for your healthcare **BEFORE** they pay your allowed benefits. Almost every procedure (major or minor) that doctors perform may be applied to your deductible. For example: if you have a yearly deductible of $1000 that you have not met, any non-cosmetic procedure, such as freezing a wart, removing cancer, biopsies, etc., will go toward your deductible. This means, you will receive a statement from our office for those charges and you will be expected to pay them in a timely manner. We reserve the right to collect deductibles up front prior to certain procedures. \_\_\_\_\_\_\_\_\_\_initial
* **INSURANCE PAYMENT QUESTIONS:** If you have any questions regarding your insurance NON-payment or denied or non-covered services, please contact your insurance company directly.

We participate with most major insurance carriers and we will bill those plans for you. However, it will be up to you to work with your insurance carrier to resolve any issues related to discrepancies with co-pays, deductible, co-insurance, or non-covered services. \_\_\_\_\_\_\_\_\_\_initial

* **SELF-PAY:** New patient self-pay office visit only charge is $114.44, established patient self-pay office visit only charge is $77.23. This amount will be collected prior to being seen. Office visit charges do not include any procedures that you may have done. You will be charged a separate procedure fee which will be collected at check out. Please inquire about procedure fee’s prior to having procedure performed, as each procedure has a different cost. For example: if you are a new patient, we will collect $114.44 when you check in, if you have a procedure done (wart frozen, biopsy, excision, injection, etc.) you will be charged an additional fee for these procedures at check out. You are expected to pay the entire cost at the time of your visit and/or procedure. \_\_\_\_\_\_\_\_\_\_initial

**ACKNOWLEDGEMENT FORM**

I acknowledge the Notice or Privacy Rights provided by Evans Dermatology and give my permission to Evans Dermatology to use and disclose my health information in accordance with it.

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Signature of patient or guarantor Name of patient (PRINT)

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Date