Joy B. Chastain, M.D., F.A.A.D.
Melissa Cannon, PA-C
Dermatology Medical History

Patient: _____ Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below: LATEX ALLERGY

1. _____ 2. _____ 3. _____ ❑ YES ❑ NO

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, Aspirin and Ibuprofen):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑

Cardiovascular	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood Clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Gastrointestinal	❑	❑
Stomach Absorption Disorder	❑	❑
Yeast infection when taking antibiotic	❑	❑
Arthritis/Joint Deformity	❑	❑
Artificial Joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Chemo/Radiation Therapy	❑	❑
Immuno Suppression Therapy	❑	❑
Type of Cancer		

Have you ever tested positive for HIV (Aids) or Hepatitis B or C ❑ YES ❑ NO Which one? _____

List any other diseases or conditions not on list:

Skin: **Have you ever had skin cancer?** ❑ YES ❑ NO Type of Skin Cancer_____

Has anyone in your family had skin cancer? ❑ YES ❑ NO Type of Skin Cancer_____

Do you have a history of any specific skin disease? ❑ YES ❑ NO

Do you develop keloids (thick scars) after surgery? ❑ YES ❑ NO

Do you develop skin rashes in reaction to: ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin

Social History:

Do you drink alcohol? ❑ YES ❑ NO If YES, _____ drinks per day

Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____

Do you smoke? ❑ YES ❑ NO If YES, how much? _____

Please answer the following questions:

(Women) Are you pregnant? ❑ YES ❑ NO Due Date ____ / ____/____

What is your occupation? _____

Signed by Patient or Guardian _____ **Date**____/____/____

Reviewed by _____ Date____/____/____

JOY B. CHASTAIN, M.D., F.A.A.D.
MELISSA CANNON, PA-C

Referring Physician: _____ Phone #: _____

PATIENT INFO:

Last Name: _____ First Name: _____ M.I._____ Social Security #: _____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work: _____ Cell: _____ Cell Service Provider:_____

Date of Birth: ____ / ____ / ____ Sex: M F Marital Status: S M D W Occupation:_____

What is your pharmacy name? _____ Phone #:_____ Location:_____

What is your e-mail? _____

Do you prefer appointment reminder via ☐ Text ☐ e-mail ☐ Both

Primary Care Physician Name:_____ Location:_____

INSURANCE SUBSCRIBER INFORMATION:

Last Name (if different from above): _____ First:_____ M.I._____

Address (if different than above):_____

Date of Birth: ____ / ____ / ____ Social Security #: _____ Relationship to patient:_____

INSURANCE:

PLEASE PRESENT YOUR INSURANCE CARD(S) AND YOUR PHOTO IDENTIFICATION TO THE RECEPTIONIST. A COPY WILL BE MADE AND RETURNED TO YOU PROMPTLY.

EMERGENCY CONTACT:

Name: _____ Relation: _____ Phone #:_____

May we leave medical information on your answering machine at home/cell? YES NO
May we call you at work? YES NO

I HAVE BEEN OFFERED THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) TO READ. (OUR BOOK IS LOCATED IN OUR WAITING ROOM)

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE OR REFERRING PHYSICIAN, TO CONSULTANTS IF NEEDED AND AS NECESSARY TO PROCESS INSURANCE CLAIMS, INSURANCE APPLICATIONS AND PRESCRIPTIONS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN.

HOW DID YOU HEAR ABOUT US? ATHENS MAGAZINE FAMILY PHYSICIAN FRIENDS
SOUTHERN DISTINCTION YELLOW PAGES WEBSITE

SIGNATURE OF PATIENT OR GUARDIAN:_____ **DATE:**_____

Joy B. Chastain, M.D., F.A.A.D.
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Financial Policy and HIPAA Requirements

The following is a statement of our financial policy which we require you to read and sign. For your convenience we accept checks, cash, Visa/Mastercard, Discover, American Express and CareCredit.

INSURANCE

We cannot file your insurance unless all of your information is given at the time of your visit. It is, therefore, necessary for us to have a current copy of your insurance card for accurate billing. It is recommended that you educate yourself about your individual benefits by contacting your insurance company. It is required that we hold you responsible for your portion of the charges, including co-pays and deductibles, at the time of service. if your insurance company has not paid within 60 days, you may receive notification in the mail requesting your assistance in determining if there is a problem, or if additional information is needed in processing the claim.

NON-COVERED SERVICES

There are a number of services that we provide that are typically considered "cosmetic" by your insurance company. For example, removals of some benign growths, such as skin tags, are not routinely covered by the health insurance plans. Other services, such as Botox, Chemical peels, Laser and Microdermabrasion are also not considered medically necessary. Full payment for all cosmetic and non-covered services must be made at the time of your visit.

REFERRALS

Since our physicians are board-certified Dermatologists in the state of Georgia, referrals are not usually required. If your insurance company does require a referral, it is solely your responsibility to obtain a current referral for office visits.

LABS

If you know that your insurance carrier requires you to use certain labs for blood work or biopsies, **you must inform our office**. Our office sends a copy of your insurance card with the specimen to an outside facility. These charges are billed directly from the laboratory itself and are separate from our office charges. You will receive an explanation of benefits (EOB) from your insurance carrier.

**Please provide the names and phone numbers of anyone that we CAN leave any of your medical information with in regards to appointment scheduling, lab work, and pathology results.

Name: _____ Phone #:_____

Name: _____ Phone #:_____

Thank you for understanding our policies. Please let us know if you have any questions or concerns. I have read the above financial policy and I understand and agree to its terms.

_____ _____

Signature of patient or responsible party **Date**

Joy B. Chastain, M.D., F.A.A.D.
Melissa Cannon, PA-C
Comprehensive Skin Cancer & Laser Center
General & Cosmetic Dermatology
Mohs Surgery & Reconstruction

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Dear Patient,

PLEASE INITIAL EACH ITEM BELOW where there is a blank line to acknowledge that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient.

___For patients with no insurance coverage, payment is due at the time of service. We accept cash, checks,Visa/Mastercard, Discover, American Express and CareCredit.

___We will bill your insurance carrier for all covered services if you are covered by a plan that we contract with as participating providers. You are required to pay for all co-payments at the time of your visit.

___For patients who have insurance coverage with a plan in which we are not participating providers, you are required to pay 50% of the balance at the time of service. You also understand that your insurance may not pay for services to a non participating provider. The remainder is due as per the policy outlined above.

___For amounts due after your insurance has processed your claim (such as deductibles not met for non-covered services), our billing company will send you two consecutive statements at 30 day intervals.

___You have 30 days after the second statement is sent to pay in full the balance indicated on the statement. If no payment is received, your account may be forwarded to our national collection agency and credit bureau for further action.

It is the responsibility of the patient to notify our office if there is any change in your mailing address or contact information.

___We do not set up payment plans for patients with outstanding balances. For patients who wish to pay off their balances over several months, we accept Visa/Mastercard, Discover, AmericanExpress and CareCredit.

Your signature below signifies that you have read each item, initialed each line, and understand your responsibilities to this office.

Signature of Patient or Guardian	**Date**

Staff Signature