LUPTON DERMATOLOGY

MR# 194199 **Today's Date:5/19/2017**

Prefix ☒Mr. ☐ Mrs. ☐Miss ☐Ms. ☐Dr. **Preferred Name:**

Patient's Name: **James** **Carrier**

First Middle Last

Address: 1249 Blackberry Ridge Rd High Point, NC 27265

Street & Apt # City State Zip

SS#: 243-90-1391 Birthdate 8/10/1951 Age: 65 Sex: ☐ Female ☒Male

Marital Status: Unspecified ☐ Single ☒ Married to: Shawn Carrier ☐ Other:

Home Phone: (336) 870-1970 Work Phone: Ext: Cell Phone: (336) 870-1970

Preferred Contact: ☐**Home** ☐ **Work** ☒**Cell** ☐**Email** **E-mail Address:** jaccis_110_02@hotmail.com

Any restrictions for contacting you? ☒No ☐ Yes If yes, please describe

Emergency Contact: Shawn Carrier Relationship to Patient: Wife Phone#: 336-870-1968

Race: ☐**African-American** ☐**Asian** ☐ **American Indian/Alaska Native** ☐**Native Hawaiian or Other Pacific Islander** ☒**White**

Ethnicity: ☐**Hispanic** ☒**Non-Hispanic** **Preferred Language:** English

How did you hear about us? ☐ Dr. Dermatologist ☐ Dr. Primary Care ☐ Newspaper ☒ Patient Referral ☐ Website ☐ Yellow Pages Details:

Referring Dr.: Dr. Edwin Green **Primary Care Dr.:** Dr. Edwin Green

INSURANCE INFORMATION

Primary Ins.: Blue Cross Blue Shield Insured: Name: James A. Carrier

Relationship to the insured? ☒Self ☐Child ☐Spouse ☐Other DOB: 8-10-1951 SS#: 243-90-1391

Secondary Ins.: Medicare Insured: Name: James A. Carrier

Relationship to the insured? ☒Self ☐Child ☐Spouse ☐Other DOB: 8-10-1951 SS#: 243-90-1391

RESPONSIBLE PARTY

Name: James A. Carrier Address: 1249 Blackberry Ridge Rd. High Point, NC 27265

Relation to Patient: Self Birth Date: 8-10-1951

PHARMACY

Pharmacy: Harris Teeter **Phone:** (336) 841-0488 **Street Name/City/St/Zip:** 1589 Skeet Club Rd #140, High Point, NC 27265

PERMISSION TO DISCUSS

Is there any other physician other than those listed above that you wish to have medical information sent to?

Name: Address:

With whom may we discuss your account?

Name: Shawn J. Carrier (wife)

Lupton Dermatology & Skin Care Center
An affiliate of
The Skin Surgery Center, PA

CONSENT FOR USE OR DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (HIPAA)

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by The Skin Surgery Center, P.A. in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review The Skin Surgery Center Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form.

The Skin Surgery Center reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If The Skin Surgery Center does change the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requisition the Notice from the Front Office Staff of The Skin Surgery Center.

I retain the right to request that The Skin Surgery Center further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Skin Surgery Center is not required to agree to such requested restrictions; however, if The Skin Surgery Center does agree to my requested restriction(s), such restrictions are then binding on The Skin Surgery Center.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to The Skin Surgery Center in writing. The revocation shall be effective *except* to the extent that The Skin Surgery Center has already taken action in reliance on the consent. *The Skin Surgery Center may refuse to treat you, if you do not sign this Consent Form* (except to the extent that The Skin Surgery Center has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

PHONE CONSENT: I AUTHORIZE THE PHYSICIANS AND STAFF OF THE SKIN SURGERY CENTER TO:

Leave a message on my answering machine or voice mail at home? X Yes ___ No Tele# 336-307-3868
Leave a message on my cell phone? X Yes ___ No Tele# 336-870-1970
Text message my cell phone? X Yes ___ No Tele# 336-870-1970
Leave a message at my place of employment? X Yes ___ No Tele# 336-307-3867
Discuss my medical condition with a member of my family or a friend? X Yes ___ No Tele# 336-332-4651

If yes, please print names: Shawn Carrier Relationship Wife
Lauren Moore Relationship Daughter
Brittany Laing Relationship Daughter

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ 08 / 10 / 1951 Date 05 / 19 / 2017
Signature of Patient Date of Birth

James A. Carrier
Please Print Name

_____ _____ _____
Signing on behalf of Patient Please Print Name Relationship to Patient

CONSENT FOR MINOR TO PRESENT FOR TREATMENT

(If a patient is under 18 - A parent or Guardian must sign)

I,_____, give my consent for my son/daughter, _____

_____ to bring himself/herself to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's signature_____ Date_____

Witness_____ Date_____

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AUTHORIZATIONS AND CONSENTS FOR PRECERTIFICATION, FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND RELEASE OF CLAIMS INFORMATION

Precertification & Financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to The Skin Surgery Center, (SSC), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to SSC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and SSC.

Authorization to Release Claims Information: I hereby authorize The Skin Surgery Center, their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits by or on behalf of any such person. I hereby authorize SSC, its employees and agents to act on my behalf in completing claims.

I HAVE READ AND FULLY UNDERSTAND THE PRECERTIFICATION & FINANCIAL RESPONSIBILITY AUTHORIZATIONS, ASSIGNMENT OF BENEFITS CONSENTS AND AUTHORIZATION TO RELEASE CLAIM INFORMATION PRINTED ON THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM. THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: _____ Date: 05 / 19 / 2017

Patient's Printed Name: James A. Carrier

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is as follows:

Signature of Authorized Representative: _____

Relationship to Patient: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

OTHER SYSTEMIC	YES	NO
Diabetes	☐	☒
Excessive thirst	☐	☒
Amputation	☐	☒
Thyroid	☐	☒
Kidney	☐	☒
Dialysis	☐	☒
Bladder	☐	☒
Frequent/burning	☐	☒
Gastrointestinal	☐	☒
Nausea, vomiting when taking antibiotics	☐	☒
Yeast infection when taking antibiotics	☐	☒
Arthritis/Joint deformity	☐	☒
Arthralgia	☐	☒
Limited motion	☐	☒
Artificial joint(s)	☐	☒
Convulsions, Epilepsy or seizures	☐	☒

SOCIAL HISTORY	YES	NO
Do you use IV drugs? If yes, what?	☐	☒
Have you had or have been exposed to HIV (AIDS)?	☐	☒
Have you had or have been exposed to hepatitis?	☐	☒
For women only: Are you pregnant? Due Date:	☐	☐

SMOKING STATUS		
Never Smoked ☒ (If never smoked, proceed to Flu shot question.)		
Former Smoker	☐	☐
Every Day Smoker	☐	☐
Social Smoker	☐	☐
Smoker, current status unknown	☐	☐
Unknown if ever smoked	☐	☐
Amount: > pack a day	☐	☐
< a pack a day	☐	☐
Started date		
Ended date		

Do you use alcohol?	☐	☒	**Have you had the flu shot within the last year?**	☒	☐
If yes, 1 - 4 drinks per week?	☐	☐	Where? Work		
5 - 8 drinks per week?	☐	☐	Are you allergic to flu shot?	☐	☒
9 - 12 drinks per week?	☐	☐	Are you allergic to eggs?	☐	☒

PNEUMONIA VACCINE	YES	NO
If you're 65 or older; have you ever received a pneumonia vaccine?	☒	☐
If yes, date 5/8/2017		
If no, circle reason: Declined vaccine Allergic to vaccine		

Do you have an advanced care plan such as a Living Will or Power of Attorney?	☒	☐

Thank you for completing your Past Medical History and Review of System forms. These will be included in your medical record.

Patient Name: James Carrier	MR#: 194199
Appointment Date: 5/19/2017	

Preferred Pharmacy (indicate location of pharmacy):

Harris Teeter Skeet Club Road Pharmacy, 1589 Skeet Club Rd #140, High Point, NC 27265

ALLERGIES – Are you allergic to any medications? **If yes, please complete section below.	MEDICATIONS - Are you currently taking any medications? ** If yes, please complete section below.
	Nexium

Allergy to numbing medications?	YES ☐	NO ☒	Yes - Details

Please list any medical conditions or surgeries of which we should be aware:

Histories

LUNGS	YES	NO
Bronchitis	☐	☒
Emphysema	☐	☒
Asthma	☐	☒
Chronic cough	☐	☒
Morning cough	☐	☒
Shortness of breath	☐	☒
Wheezing	☐	☒
CARDIOVASCULAR	**YES**	**NO**
High blood pressure	☐	☒
Chest pain	☐	☒
Heart attack	☐	☒
Heart murmur	☒	☐
Irregular heart beat	☐	☒
Phlebitis	☐	☒
Blood clots	☐	☒
Inflammation of vein	☐	☒
Pacemaker	☐	☒

SKIN	YES	NO
Do you sunburn easily?	☐	☒
Have you ever had abnormal moles?	☐	☒
Have you ever had skin cancer?	☐	☒
Has anyone in your family had abnormal moles?	☒	☐
Has anyone in your family had skin cancer?	☐	☒
Do you have a history of any specific skin diseases? If yes, please list	☐	☒
Do you have problems with healing?	☐	☒
Do you develop keloid (scars) after surgery?	☐	☒
Do you bleed easily?	☐	☒
Do you develop skin rashes in reaction to:	**YES**	**NO**
Medications	☐	☒
Food	☐	☒
Environment	☐	☒
Bandages	☐	☒
Poison Ivy	☒	☐
Jewelry	☐	☒
Topical Neosporin	☐	☒
Other	☐	☒