

**PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Referring Doctor \_\_\_\_\_  
Primary Care Doctor \_\_\_\_\_

**Reason for today's visit:**

**History of today's problem(s):**

**Skin areas involved:**

**How long has the problem been present?**

**Was a biopsy done?** No Yes **Who did the biopsy?** Referring MD Other \_\_\_\_\_

**Was there any previous treatment?** No Yes **What was done and when?** \_\_\_\_\_

**Previous skin cancer?** No Yes **Previous Mohs surgery?** No Yes \_\_\_\_\_

Check all that apply regarding today's problem: None Apply

CHANGE IN: Size Color Elevation Hardness

HISTORY OF: Bleeding Tingling/itching Pain Ulceration

Infection Occasional symptoms Constant symptoms

RISK FACTORS: X-ray treatments (not routine X-rays) UV light treatments

Arsenic exposure Immunosuppression

PLEASE LIST ALL MEDICATIONS & DOSAGES (Including vitamins, herbs and supplements)

MEDICATION ALLERGIES: None List:

Check ALL that apply regarding your overall health and add any other medical problems:

**CARDIOVASCULAR**

- Normal
- Artificial valve
- Pacemaker
- High blood pressure
- Heart Attack (when?)
- High Cholesterol
- Bypass/other surgery
- Mitral valve prolapse
- Other heart problem

**GASTROINTESTINAL**

- Normal
- Stomach Ulcer
- Colitis
- Irritable bowel

**NEUROLOGICAL**

- Normal
- Stoke
- Seizures
- Alzheimer's

**PSYCHIATRIC**

- Normal
- Depression
- Anxiety disorder
- Other

**BLOOD/LYMPH**

- Normal
- Anemia
- Enlarged lymph nodes
- Bleeding problems

**RESPIRATORY**

- Normal
- Emphysema
- Asthma

**ENDOCRINE**

- Normal
- Diabetes
- Thyroid problem

**SKIN**

- Normal (besides skin cancer)
- Poor/slow healing
- Keloids

**General**

- Normal
- Fever/Weight loss

**INFECTIONS**

- Normal
- Hepatitis
- HIV/AIDS
- Tuberculosis

**MUSCULOSKELETAL**

- Normal
- Arthritis
- Artificial joint
- Fibromyalgia

**HEAD/NECK**

- Normal
- Hearing aid
- Glaucoma
- Plastic surgery

OTHER MEDICAL PROBLEMS: \_\_\_\_\_

MAJOR ILLNESSES/HOSPITALIZATIONS: none List: \_\_\_\_\_

FAMILY HISTORY: Melanoma Other skin cancers Bleeding Problems

Other major medical problems: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital status: S M D W

Do you wear: Dentures Glasses Contacts

Smoking: No Former Yes; packs per day? \_\_\_\_\_

Alcohol: No Social/occasional drinking

Alcohol or drug problems/addictions: No Yes (please describe) \_\_\_\_\_

Updated \_\_\_\_\_ Updated \_\_\_\_\_ Updated \_\_\_\_\_

Updated \_\_\_\_\_ Updated \_\_\_\_\_ Updated \_\_\_\_\_

**GEORGIA DERMATOLOGIC SURGERY CENTERS, P.C.**

**MARK F. BAUCOM, M.D.**

**THE MEDICAL QUARTERS, SUITE G-65**

**5555 PEACHTREE-DUNWOODY RD.**

**ATLANTA, GA 30342**

**PH)404/943-1996 Fx)404/943-9464**

**PATIENT DEMOGRAPHIC INFORMATION**

Date: \_\_\_\_\_

Updated: \_\_\_\_\_

Updated: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

County: \_\_\_\_\_

Phone# Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Email: \_\_\_\_\_

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\*\* Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## List of Aspirin or Aspirin Related Drugs

**PLEASE DO NOT TAKE ANYTHING ON THIS LIST**

4-Way Cold Tablets	Duoprin-S Syrup	Norwich Extra-Strength Tablets
Adprin – B Tablets	Duradyne Tablets	Nuprin Tablets and Caplets
A.S.A. Enseals	Easprin	Orphengesic
A.S.A. Tablets	Ecotrin Tablets	Orudis Capsules
Aches-N Pain Tablets	Emagrin Tablets	Oruvail Capsules
Advil	Empirin Tablets	Pabalate
Aleve Tablets	Emprazil	Pabalate-SF Tablets
Alka-Seltzer Products	Endodan Tablets	PAC Tablets
Amigesic Capsules	Epromate Tablets	Pamprin-IB Tablets
Anacin Tablets and Capsules	Equagesic Tablets	Pepto-Bismol Tablets and Suspension
Anaprox	Equazine M Tablets	Percodan and Percodan- Demi Tablets
Anaprox DS Tablets	Etodolac	Phenaphen
Anodynos Tablets	Excedrin Tablets and Capsules	Piroxicam Capsules
Ansaid Tablets	Feldene Capsules	Plavix**
APC	Fenoprofen Tablets	Ponstel Capsules
Argesic Tablets	Feverfew Dietary Supplements	Presalin Tablets
Artha-G Tablets	Fiorgen PF Tablets	Relafen Tablets
Arthralgen Tablets	Fiorinal Tablets	Robaxisal Tablets
Arthritis Bayer Timed Release Aspirin	Fluriprofen Tablets	Rufen Tablets
Arthritis Pain Formula Tablets	Garlic Dietary Supplements	S-A-C
Arthritis Strength Bufferin Tablets	Gelpirin Tablets	Saletto, All Products
Arthropan Liquid	Gensan Tablets	SalFlex Tablets
Arthrotec	Ginger Dietary Supplements	Salocol Tablets
Ascocleen	Ginko Biloba Dietary Supplements	Salsalate Tablets
Ascriptin, All Products	Goody's Headache Powder	Salsitabs Tablets
Asperbuf Tablets	Halfprin Tablets	Sine-Aid
Aspergum [chewing gum]	Haltran Tablets	Sine-Off
Aspirin	Haltran Tablets	SK-65 Compound Capsules
Asprimox Tablets	Ibu-Tab Tablets	Soma
Axdone	Ibuprin Tablets	Soma CMD
Axotal Tablets	Ibuprohm Tablets and Caplets	St. Joseph Adult Chewable Aspirin
Bayer, All Products	Indochron E-R Capsules	St. Joseph Cold Tablets for Children
BC Tablet and Powder	Indocin Capsules/Suspension/ Suppositories	Sulindac Tablets
Brufen	Indocin-SR Capsules	Supac
Buf-Tabs	Indomethacin Capsules	Synalgos Capsules
Buff-A Comp Tablets and Capsules	Indomethacin Suspension	Synalgos-DC Capsules
Buffaprin Tablets	Isolly Improved Tablets and Capsules	Talwin Compound Tablets
Bufferin, All Products	Ketorolac Tablets	Tolectin 200,600 Tablets
Buffets II Tablets	Ketoprofen Capsules	Tolectin DS Capsules
Buffex Tablets	Lanorinal Tablets	Tolmetin Tablets/Capsules
Buffinol Tablets	Lodine Capsules/Tablets	Toradol Injection/Tablets
Cama Arthritis Pain Reliever	Lodine XL	Trendar Tablets
CataFlam Tablets	Magan Tablets	Tricosal Tablets
Caphalgesc	Magnaprin Arthritis Strength Caplets	Tri-Pain Tablets
Cheracol	Magsal Tablets	Trigesic Tablets
Children's Aspirin	Marnal Capsules	Trilisate Tablets and Liquid
Children's Advil Suspension	Marthritic Tablets	Vanquish Caplets
Children's Motrin Suspension	Maximum Bayer Aspirin	Verin
Clinoril Tablets	Measurin Tablets	Vitamin E Supplements
Clopidogrel**	Meclofenamate Capsules	Voltaren Tablets
Congesprin	Meclomen Capsules	Warfarin**
Cope Tablets	Medipren Tablets and Caplets	Zactin
Coricidin	Menadol Tablets	Zorprin Tablets
Coumadin**	Meprogesic Tablets	
Darvon Compound Pulvules	Micrainin Tablets	
Darvon Compound -65	Midol, All Products	
Darvon with A.S.A. Pulvules	Mobidin Tablets	
Darvon-N with A.S.A.	Mobigesic Tablets	
Dasin Capsules	Momentum Tablets	
Daypro Tablets	Motrin Tablets	
DiFlunisal	Nalfon Capsules/Tablets	
Disalcid Capsules	Nalfon Pulvules	
Doan's Pills	Naprosyn Tablets/Suspension	
Dolobid Tablets	Naproxen Tablets	
Dong Quai Dietary Supplements Or Herbal Tea	Neocylate Tablets	
Dristan	Norgesic & Norgesic Fortc Tablets	

\*\*Please check with your prescribing doctor before stopping these medications.

# NOTIFICATION OF OWNERSHIP AND ADVANCE DIRECTIVES

## DISCLOSURE OF OWNERSHIP INTEREST

In accordance with Federal ASC Regulations (42 C.F.R. 416.50 (a) (ii)), the following ownership disclosure is made in advance of the procedure.

ASC of Georgia Dermatologic Surgery Centers, LLC, is owned by the physicians of Georgia Dermatologic Surgery Center, PC. The physician who will be performing your procedure is an owner. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than ASC of Georgia Dermatologic Surgery Centers, LLC.

By signing below, you, or your legal representative, acknowledge that this disclosure has been made in advance of the date of the procedure, and that you have decided to have the procedure performed at the ASC of Georgia Dermatologic Surgery Center, LLC.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## ADVANCE DIRECTIVES

In order to be in compliance with the Self-Determination Act (PSDA) and Georgia state law and rules regarding advance directives, the Facility requires each patient prior to scheduled procedures to read and acknowledge the Facility position on advance directives.

**Advance Directives** are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury. There are many types of advance directives, but the two most common forms are:

**Living Wills.** These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions

**Durable Power of Attorney for Health Care.** This is a signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decision for that individual if he/she should become unable to make his/her own decisions.

In the event of a medical emergency or other life-threatening situation, resuscitation will be instituted in every instance and patients will be transferred to a higher level of care.

Any previously formulated advance directives will not be honored at the Facility. If for any reason you disagree with this policy, please discuss your concerns with your physician before arriving for your scheduled procedure.

I have read and acknowledge that the Facility does not honor Advance Directive.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

*If the patient is unable to sign or is a minor, please sign.*

Relative/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT RIGHTS AND RESPONSIBILITIES

*In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of the ASC of Georgia Dermatologic Surgery Centers, L.L.C.*

### Every Patient Has the Right

- To** be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- To** be free of all forms of abuse or harassment.
- To** an environment that is safe and secure for self and property.
- To** confidentiality of information gathered during treatment.
- To** know what rules and regulations apply to his or her conduct.
- To** refuse treatment, except as otherwise provided by law.
- To** receive impartial access to medical treatment or accommodations, regardless of age, race, national origin, religion, physical handicap, or source of payment.
- To** express grievances regarding any violation of his or her rights, through the grievance procedure of the health care provider which served him or her.
- To** exercise his or her rights without being subjected to discrimination or reprisal.
- To** prompt and reasonable response to questions and requests.
- To** know who is providing and is responsible for his or her care.
- To** know, upon request and in advance of treatment, whether the health care provider or health care practice accepts the Advance Directives.
- To** know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To** be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- To** receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- To** know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research.

- To** participate in all aspects of health care decisions, unless contraindicated by concerns for their health.
- To** appropriate assessment and management of pain.
- To** be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- To** receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To** receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.

### Every Patient is Responsible

- For** providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For** reporting unexpected changes in his or her condition to the health care provider.
- For** reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- For** following the treatment plan recommended by the health care provider.
- For** keeping appointments and when he or she is unable to do so for any reason, for notifying the Practice
- For** his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- For** assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For** following Practice rules and regulations affecting patient care and conduct.
- For** consideration and respect of the Practice staff and property.
- For** asking what to expect regarding pain and pain management

You and your family should feel you could always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss you concerns with your doctor, nurse, or other caregiver. If you have concerns that are not resolved, please contact James Courtney, Office of Regulatory Services, Two Peachtree Street NW, 31<sup>st</sup> floor, Atlanta, GA 30303 or at 404-657-5700. You may also contact the Office of the Medicare Beneficiary Ombudsman at [www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp)

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

**PAYMENT OF FEES**

Full payment is expected at the time of service. If we accept your insurance, you must pay your co-pay, deductible and/or co-insurance, and pay in full for any non-covered or denied services. Receipt of services shall constitute your acceptance of this financial obligation. We accept MasterCard, Visa, American Express, and Discover, as well as your personal check or cash. If your check is returned to us by your bank for any reason we will charge you the maximum fee allowed by law at that time. Overdue accounts will be turned over to our collection agency and reported to the credit bureau. You will be responsible for any fees involved in the collections process, including any legal fees incurred.

Sign here to acknowledge that you have read and understand all these terms:

X \_\_\_\_\_

How will you pay for your services today? CASH \_\_\_\_\_  
CHECK \_\_\_\_\_ DEBIT CARD \_\_\_\_\_ CREDIT CARD \_\_\_\_\_

**INSURANCE INFORMATION**

We file claims only if we are contracted with your insurance company or if your insurance company has an out-of-network access agreement with one of our contracted plans. Otherwise we will provide you with properly coded receipts so you can file yourself. Please be aware that you are ultimately responsible for all fees, regardless of your insurance coverage. You may request a pre-treatment fee estimate, but under Georgia law it is not our responsibility to determine your insurance coverage or to explain your benefits to you. **WE ARE NOT MEDICAID PROVIDERS.**

PRIMARY INSURANCE: \_\_\_\_\_ TYPE OF PLAN (HMO, PPO, ETC) \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ RELATION TO YOU: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ GROUP NAME: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ TYPE OF PLAN \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ RELATION TO YOU: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ GROUP NAME: \_\_\_\_\_

**LABORATORY TESTING**

All specimens taken here are sent to Finan Templeton Dermatopathology Associates. If you need to use any other lab, please check here \_\_\_\_\_ and tell receptionist.

**ACKNOWLEDGEMENT OF RESPONSIBILITY AND ASSIGNMENT OF BENEFITS**

I assign to Georgia Dermatologic Surgery Centers all payments for medical services they render to me. I understand that services are provided in good faith and I agree to be fully responsible for any services denied by my insurance, including services denied as not medically necessary. This shall serve as my informed consent. I certify that this coverage is in effect now, and I agree to inform this office in writing of any changes.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RETURN THIS FORM TO THE RECEPTIONIST WITH YOUR INSURANCE CARD AND A PICTURE I.D.