Manju Elizabeth George, M.D., PLLC

Patient Information

Please complete the following information: **Today's Date: _____**

PATIENT'S NAME:_____ _____ _____
LAST **FIRST** **MIDDLE**

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

DATE OF BIRTH:____/____/ **AGE:**_____ **MALE**_____ **FEMALE**_____

HOME PHONE_____ **CELL (MOM)** _____ **CELL (DAD)**_____

EMAIL ADDRESS: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____
NAME **PHONE#**

PATIENTS PRIMARY CARE MD: _____ **NAME**
PHONE

PARENT/ LEGAL GUARDIAN INFORMATION

PERSON RESPONSIBLE FOR MINOR:_____**Relationship** _____

FATHER:_____**DOB**_____

FATHER'S EMPLOYER:_____
NAME **PHONE#: WORK**

MOTHER:_____**DOB**_____

MOTHER'S EMPLOYER:_____
NAME **PHONE#: WORK**

☐ **Check if copy of card provided and do not fill below**

INSURANCE COVERAGE

POLICY HOLDER'S NAME:_____**RELATIONSHIP TO PATIENT**_____

INSURED'S DATE OF BIRTH: _____

INSURANCE COMPANY: _____

POLICY NO:_____**GROUP NO:** _____

I hereby state that the above information is current and correct and authorize the release of any information required to complete this or any future claim and also authorize payment of medical services to me, for professional services to Manju E. George, M.D., PLLC. I further authorize a copy of this authorization to be used in place of the original.

BY SIGNING BELOW, I AGREE TO PAY ALL EXPENSES REGARDLESS OF INSURANCE RESPONSIBILITY.

_____ _____
Signature Date

Manju Elizabeth George, M.D.
PLLC Pediatric Dermatology
Medical History Form

Patient Information:

Name of Child: Age: Person Providing Information:

Relationship: **PHARMACY LOCATION**

PEDIATRICIAN/GROUP_____

Reason of Today's Visit: _____
Duration: _____
Treatment to Date:

_____

_____

Past Medical History:
Newborn: Birth History: □ Vaginal □ C-Section Birth Weight:_____lbs._____
oz. Prior surgeries or hospitalizations? (Including NICU stay)

_____

List Current Medications: _____
Allergic to: □ Band-aid □ Tape □ Adhesives
Allergies to Medications:_____Food:_____
Are immunizations up to date?_____YES_____NO

Medical History:

	Yes	or	No
Eczema:	□		□
Asthma:	□		□
Seasonal Allergies:	□		□
Weight Gain/Loss:	□		□
Eye/Ear/Nose/Throat Symptoms:	□		□
Skin Cancer/Melanoma:	□		□
Epilepsy/Seizure Disorder:	□		□
Psychiatric Problems:	□		□
Cardiac Disorders:	□		□
Breathing Difficulties:	□		□
Stomach Pain:	□		□
Vomiting/Diarrhea/Nausea:	□		□
Endocrine Problems:	□		□
Muscle Aches/Weakness:	□		□

Other: _____

If yes, please explain: _____

_____

_____

Females only:	Yes or No
Are you pregnant?	□
Birth Control?	□

Family History:	Yes	or	No
Melanoma:	□		□
Non-Melanoma:	□		□
Eczema:	□		□
Asthma:	□		□

Allergies: _____

Other: _____

_____

MANJU ELIZABETH GEORGE, M.D., PLLC

PATIENT HIPPA/ AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). **The patient or their parent or guardian understands that:**

Protected health information may be disclosed or used for treatment, payment or health care operations.

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The Patient may revoke this authorization in writing at any time and all future disclosure will then cease.
- The Practice may condition receipt of treatment upon the execution of this Authorization.

PRACTICE POLICIES: In order to serve your needs better, we ask that you read our policies and sign below.

1. We request a 24 hour (1 full business day) cancellation notice. Failure to call or "no shows" will be charged a $50.00 administrative fee that is not billable to insurance. Surgery "no shows" will be charged $50.00.
2. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy to request refills.
3. If a patient loses their lab requisition form, there is a $5 administrative fee.
4. Co-pays and deductibles are due at the time services are rendered.
5. Patients are responsible for verifying insurance coverage.
6. We attempt to make courtesy phone calls to remind you of your appointment but are unable to provide this service at all times. If you do not receive a reminder phone call and forget to come to your appointment, this does not cancel our "no show" policy above.
7. All returned checks will be charged a $25.00 administrative fee.
8. If past bills are sent to collections, there will be a surcharge to cover the cost of the collection agency.
9. Some insurance plans consider any procedure (such as skin scraping, wart or molluscum treatment) to be a surgery. As such, these procedures may be subject to a separate deductible.
10. We are happy to see any and all children in your family, but a separate appointment is required for each child.

I acknowledge that I have read the above authorization and have had access to read Manju E. George, M.D., PLLC full notice of Privacy Practices. I have read, understand, and agree to adhere to the practices policies above.

Printed Name – Patient or Representative _____ **Relationship to patient** _____

Signature _____ **Date** _____

☐ **Patient consent for Medical photography**

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

☐ **Patient Consent of Release of information to PCP/consultants**

I authorize the release of medical information to my primary care or referring physician and/or to any consultants if needed as necessary to process insurance claims, applications, and prescriptions or for management of patient's medical condition.

☐ **Telephone Authorization**

I hereby authorize that the office staff of Manju Elizabeth George MD PLLC or Dr. George herself may leave a message at home or cell phone number listed regarding the results of any biopsies, laboratory or X-ray information or any other pertinent lab results that may be done today or at a future visit.

Please initial or "X" box if you authorize. This initial or "X" states that you agree to the statements above.