Manju Elizabeth George, M.D., PLLC

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.

Please Sign_____

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

Patient Information:

Name of Child: _____ Age: _____
Person Providing Information: _____
Are Immunizations Current: Yes_____/ No _____
PHARMACY NAME & NUMBER: _____

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

_____

_____

Past Medical History:
New Born: 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: _____

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:	□		□

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

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

Other:
_____
_____

Other Medical History: _____

PATIENT HIPAA AUTHORIZATION FORM

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 (HIPAA).

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.

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.

_____ _____

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 a patient's medical condition.

Telephone Authorization

_____I hereby authorize 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.

PRACTICE POLICIES:

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

1. Appointment Cancellations & No-Shows - We require at least 24 hours (1 full business day) notice for appointment cancellations. Missed appointments or cancellations made with less than 24 hours' notice will incur a $35 administrative fee, which is not covered by insurance.

- After **three (3) no-show appointments**, our office reserves the right to discharge you from our practice due to non-compliance with our policies.

2. Prescription Refills - Please allow **2 business days** for prescription refill requests to be processed.

3. Payment Policy

- **Co-pays, co-insurance, and deductibles** are due **at the time of service.**
- Please note: **Payments made by credit card will be subject to a credit card processing fee of 3%*****

4. Records Requests

All **medical records requests** can take **up to 30 days to process**, in accordance with state and federal law.

5. Insurance Verification

It is the patient's responsibility to **verify coverage and benefits** with their insurance provider prior to the visit.

6. Appointment Reminders

We make **courtesy reminder calls** when possible.

- However, if you do **not receive a reminder**, this does **not exempt you** from our **no-show policy**.

7. Returned Checks

Any **returned check** will incur a **$25 administrative fee.**

8. Collections

Accounts sent to a **collections agency** may be subject to an additional **surcharge** to cover administrative and processing costs.

9. Insurance Classification of Procedures

Some insurance plans classify certain procedures—such as **skin scrapings, wart or molluscum removal**—as **surgical**.

- These may be subject to **separate deductibles or out-of-pocket charges**

_____ _____

Signature **Date**