Please fill out all highlighted areas on 3 pages

Date:_____

Name: _____ DOB: _____

Reason for Visit: _____

Personal Past Medical History: (Please check all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation (Irregular Heartbeats)
- COPD (Emphysema)
- Coronary Artery Disease
- Depression
- Diabetes
- GERD (Acid Reflux)
- Hepatitis
- Hypertension (High Blood Pressure)
- High Cholesterol
- HIV/AIDS
- Hyperthyroidism
- Hypothyroidism
- Pacemaker/Defibrillator
- Radiation Treatment
- Seizures
- Stroke
- Valve Replacement
- Kidney Disease

Cancer: _____ Other: _____

Surgery History: (Please list) _____
_____

Skin Disease History: (Please check all that apply)

- Actinic Keratoses (Pre-Cancer)
- Eczema
- Basal Cell Skin Cancer
- Blistering Sunburn
- Dry Skin
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Psoriasis
- Squamous Cell Skin cancer

Do you wear Sunscreen Daily? Yes No If yes, What SPF: _____

Medications: (Please List All Current Medications, Including Aspirin) _____
_____
_____

Have You Had Your Flu Vaccine? YES _____ NO _____
Have You Had Your Pneumonia Vaccine? YES _____ NO _____

Allergies: _____
_____

Social History: (Please check one)

Smoking
____ YES _____ NO _____QUIT (Date)

Alcohol Use
____ YES _____ NO

Family History: Do you have a family history of Melanoma? ____ YES _____ NO
If yes, which relative(s): _____

SKIN CANCER CENTRE

Authorization for verbal communication & to leave messages on home answering machines and cell phone voicemails regarding my personal health information, pathology results, and future appointments.

Patient Account #_____

Patient Information

Name- Last, First, MI	Date of Birth:

Information to be disclosed: verbal communication only regarding patient's care
Please provide your current telephone numbers

Home Phone	Cell Phone
Work Phone	Other Phone

We normally contact our patients between 8 a.m. and 7 p.m. Monday through Friday. Please **check below** where you would prefer to be contacted during these hours.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

If we need to reach you after hours, please **check below** where you prefer to be called:

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Your Protected Health Information Designees: If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf.

Please print the name and relationship to you/patient of each designee below:

Designee Name:	Telephone # & Relationship to Patient:
Designee Name:	Telephone # & Relationship to Patient
Designee Name:	Telephone # & Relationship to Patient

_____ Check here if you ***do not want*** your health care information discussed with anyone other than yourself.

Confidential Voice Mail:
Please check below where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) **blank** if you **do not wish** to receive voice mails.

Home Phone_____ Cell Phone_____ Work Phone_____ Other Phone_____

Please **PRINT** an email address that we can send you a invite to participate in our new patient portal. We do not sell your email address or use it for any other reason other than your direct care at our office.

Yes/No - SCC may release any photographs or slides of me including electronic release through the use of E-mail for consultation and/or training purposes with any other medical personnel as deemed appropriate by Dr. DeAngelis.

Email Address:

Your signature **below** confirms your approval of these updated HIPAA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE SIGNED**

_____Staff Initials

PATIENT INFORMATION

Name _____

Address _____

_____

Date of Birth _____ Sex _____ Race _____

Social Security Number _____

Primary Care Physician: _____

Who Referred You to Us: _____

Preferred Pharmacy: _____

BRING YOUR INSURANCE CARDS WITH YOU

If your spouse/parent is the policy holder:

Spouse Name: _____ Date of Birth: _____

Social Security Number: _____ Employer: _____

I authorize Skin Cancer Centre, to release to my insurance companies any information required for services provided. I permit a copy of this authorization to be used in place of the original and request that payment of insurance benefits are assigned to Skin Cancer Centre.

_____

Financial Policy

I understand that I remain responsible to the Skin Cancer Centre, for any and all charges not met by the payment of the assignment above and for all charges should said payment not be paid within a responsible time after charges are filed with the insurer.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, payment is due at the time of service. Our office accepts payment by cash, check, Visa or MasterCard, and American Express.

Our fees reflect the usual and customary charges for this area. However, our fees may vary slightly from the usual and customary fees cited by insurance companies, which often include non-specialist fees and out-dated fees in their computations.

Your Insurance

We have contracts with many insurers. We will bill those plans with which we have a contract and will collect any co-payment from you at the time of your service. In the event your health plan determines a service to be "not covered", you will be responsible for the charges. In that event, we will bill you and payment is due upon receipt of the statement, although, in certain circumstances, reasonable payment plans may be established.

If you have insurance coverage with a plan that we do not have an agreement with, we will prepare and send the claim for you as a courtesy. Charges for your care and treatment are due at the time of service unless other arrangements are made by you with us in advance.

Minor Patients

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

I have read and understand the financial policy of The Skin Cancer Centre, P.A. and I agree to be bound by its terms.

_____ _____

Responsible Party Patient's Signature

Date: _____ Date: _____

SKIN CANCER CENTRE

Richard J. DeAngelis, M.D.
April S. Ross, PA-C. | Ashlyn A. Platts, PA-C.
1409 N. Fant Street (Building A) & 1221 N. Fant Street (Building B)
ANDERSON, SC 29621
864-231-8599 or 1-800-972-3751

If you are seeing April Ross or Ashlyn Platts – you will be seen in Building B

From Greenville Area: Hwy I-85 S. to **Exit 27**. **Left** onto **Hwy 81 N**., drive approximately **8.7 miles** to the intersection of E. Greenville Street & N. Fant Street. Turn **right** onto **N. Fant Street**, go approximately 3 blocks and the offices are on the **left**, across from the Clemson Eye - Eye Care Center.

From Georgia Area: Hwy I-85 N. to **Exit 19-A**. Merge onto **Clemson Blvd**, drive approximately **4.8 miles**, until you see the US Post Office and Ingles Supermarket on the left. Turn **left** at the stop light onto **Boulevard**, go to the next traffic light, **turn** right onto **N. Fant Street**, go approximately 2 blocks, and the offices will be on your right.