South Carolina Skin Cancer Center
Registration Form
(Please Print)

PATIENT INFORMATION				
Last name: First: Middle Initial:			☐Mr. ☐Miss ☐Mrs. ☐Ms. ☐M.D. ☐ PhD ☐_____	☐Single ☐Married ☐Other ☐Divorced ☐Widow/Widower
Social Security Number:	Home Phone Number:	Cell Phone Number:	Birth date: / /	Sex: ☐M ☐F
Would you like access to the patient portal online? ☐ Yes ☐ No		Email Address (for patient portal):		
Street Address/P.O. Box:				
City:	State:	Zip Code:	**Primary/Family Doctor's Name (first and last name) & Address:**	

INSURANCE INFORMATION		
Please give your insurance card to the receptionist.		
Primary Insurance Name:		
Subscriber's Name (If different from patient):	Subscriber's Birth date: / /	Copayment:
Secondary Insurance (if applicable):		

Messages may be left on my answering machine regarding appointments, lab results, pre and post surgery instructions, billing/insurance or account information: ☐YES ☐NO		
We may discuss your medical condition with a member of your household: ☐ YES ☐NO		
If yes, whom:	Relationship:	Phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the South Carolina Skin Cancer Center. This includes all major medical benefits, Medicare and government sponsored programs, private insurance, or other. I hereby authorize the South Carolina Skin Cancer Center to release all information necessary, including medical records, to secure the payment of insurance benefits. This assignment of benefits will remain in effect until revoked by me in writing. I understand that I am responsible for all applicable CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, and NON-COVERED SERVICES as required by my insurance policy.

Patient Signature:	Date:

IMPORTANT: Please fill these forms out and bring them with you on the day of your appointment – they do not need to be returned to our office prior to your appointment

SOUTH CAROLINA SKIN CANCER CENTER
FINANCIAL POLICY AND AUTHORIZATION

Patient Name: _____

Thank you for choosing James R. DeBloom, M.D. as your provider. Dr. DeBloom and his staff are committed to providing you with the best medical care. Please read this form carefully as it outlines our policy regarding payment and authorization to file your medical insurance claim. A copy will be provided upon request.

All patients should provide accurate and complete personal and insurance information prior to your appointment. It is the patient's responsibility to make sure that we have your most recent information. If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. All applicable co-pays and any prior balances are due at the time of service.

James R. DeBloom, M.D. has preferred provider contracts with most insurance companies. Your insurance coverage is a contract between you and your insurance company. James R. DeBloom, M.D. is not responsible for services denied by your insurance company. Please be aware that it is your responsibility to obtain any necessary referrals and authorizations prior to your appointment. It is also your responsibility to know if your insurance company requires a referral prior to your appointment.

Financial Authorization: I hereby authorize my physician to bill my insurance company for services rendered. I also assign to my physician any insurance or other third-party payments for services provided to me. I understand that my physician has the right to refuse or accept assignment of such benefits. If these benefits are not paid to my physician, I agree to forward all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. I am responsible for the payment of all charges for services rendered to the above patient. Payment will be made promptly, as bills are presented, with settlement in full or appropriate arrangements for settlement made.

The undersigned certifies that he/she has read this document and that he/she is the patient or is duly authorized by the patient as the patient's general agent to execute these consents and agreements and accept these terms:

Payments: We accept cash, checks, Visa, MasterCard, Discover, and American Express. Upon receipt of billing statements, outstanding balances are due within 30 days. Should your account become past due, it may be sent to a collection agency.

Please be aware that there may be an office visit charge and co-pay required for surgical patients seen in follow-up depending on the timing of that appointment.

Missed Appointments: There is a $50 charge for appointments that are missed. If you must cancel an appointment, please call and let us know at least 24 hours prior to that appointment. Missed appointments directly result in a delay of treatment for another cancer patient. After two consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

By signing below, you acknowledge you have carefully read, understand, and agree to the above terms.

Signed: _____ **Date: _____**

SOUTH CAROLINA SKIN CANCER CENTER

Please answer **ALL** questions by checking the correct bubble.
Please do not write anything on this sheet. Thank you.

HISTORY OF CURRENT LESIONS:

Have the lesions changed in size?	O Yes	O No
Have the lesions changed in color?	O Yes	O No
Have the lesions been bleeding?	O Yes	O No
Are the lesions painful?	O Yes	O No
Are the lesions itching?	O Yes	O No
Do the lesions have constant symptoms?	O Yes	O No
Do the lesions only have occasional symptoms?	O Yes	O No
Was a biopsy done?	O Yes	O No
Was there any treatment done other than biopsy?	O Yes	O No

PAST MEDICAL HISTORY (Answer all questions)

History of Basal Cell Carcinoma	O Yes	O No
History of immunosuppression	O Yes	O No
History of Melanoma	O Yes	O No
History of Squamous Cell Carcinoma	O Yes	O No
Organ Transplant recipient	O Yes	O No

CARDIOLOGY

Artificial or abnormal heart valve	O Yes	O No
Chest pain/Angina	O Yes	O No
High Blood pressure	O Yes	O No
Pacemaker or Defibrillator	O Yes	O No

CONSTITUTIONAL

Fever	O Yes	O No
Weight Loss	O Yes	O No

DERMATOLOGY

Abnormal scarring	O Yes O No
Poor Healing	O Yes O No

ENDOCRINOLOGY

Diabetes	O Yes O No
Thyroid disorder	O Yes O No

ENT

Glaucoma	O Yes O No
Hearing Aid	O Yes O No

HEMATOLOGY

Bleeding Problems	O Yes O No
Blood transfusions	O Yes O No
Enlarged lymph nodes	O Yes O No

INFECTIOUS DISEASE

Hepatitis	O Yes O No
HIV/AIDS	O Yes O No

MUSCULOSKELETAL

Arthritis	O Yes O No
Artificial joints	O Yes O No

NEUROLOGY

Seizures	O Yes O No
Stroke	O Yes O No

PSYCHOLOGY

Anxiety	O Yes O No
Depression	O Yes O No

RESPIRATORY

Asthma	O Yes O No
Emphysema or COPD	O Yes O No

UNIVERSAL MEDICATION FORM

Name:
Phone Number:
Birth Date:
Emergency Contact:

Allergic To:	

****** If no known drug allergies please check the box: NKDA** ☐

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription medications, over-the-counter medications and herbals. Include medications taken as needed.

NAME OF MEDICATION	DOSE	DIRECTIONS: Use patient friendly directions.	Notes: Reason for taking

Please Note: You do not need to discontinue any prescription medications prior to your surgery with us.

Surgical History – Past Ten Years

Surgeries	Year

Hospitalizations – Past Ten Years

Reason for Hospitalization	Year

Vaccinations (Most recent)

Flu	**Yes___ No____**	**Month: ___ Year: ____**
Pneumonia	**Yes___ No____**	**Month: ___ Year: ____**

Advance Care Plan (ACP) or Surrogate Decision Maker

Yes (ACP) ___	If you have a surrogate decision maker, please list their name:
No (ACP or Surrogate decision maker) ___	Surrogate decision maker: _____