



## Welcome to Dermatologic Surgery of the Carolinas!

Enclosed you will find several information forms to fill out prior to your arrival at our office for you appointment. **Please bring them with you on your appointment day.** The enclosed forms include:

- Patient information form
- Medical history form
- Signature form for Privacy Policy (HIPAA), Financial Policy, and Release of Medical Information
- Directions to our office

If you should have any questions regarding your appointment, insurance coverage or the Mohs procedure, please do not hesitate to contact our office at (803)329-0888. Here at Dermatologic Surgery of the Carolinas we strive to provide top-quality, cutting-edge treatment of skin cancer and other dermatological conditions so please do not hesitate to contact us if you have any questions or concerns.

Along with the enclosed forms, please bring the following to your upcoming appointment:

- **Insurance card** (Dr. Lane cannot see you without verifying your insurance with your insurance card)
- **Co-pay or Deductible** (We will verify this with you prior to your appointment time)

Completing these forms with their required signatures and having your insurance card and co-pay/deductible can dramatically decrease the time required for check-in, so we appreciate your assistance and we look forward to your visit.



DERMATOLOGIC SURGERY  
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**Patients MUST sign and date all paragraphs below before medical care can be rendered.**

**PATIENTS WHO ARE MINORS: If the patient is younger than eighteen, then the paragraphs must be signed by a parent or legal guardian. A parent or legal guardian must be present for any patient younger than sixteen.**

**Release of Medical Information**

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Financial Policy**

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. We accept payment in the form of cash, check, Visa and MasterCard. In the event that your account must be turned over to collections, a \$25.00 collection fee will be added to your account. There is a \$30 fee for any returned check. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand this financial policy statement. I agree to make in-full prompt payment to Dermatologic Surgery of the Carolinas when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Privacy Practices (HIPAA)**

By signing below, I acknowledge that I have read and understand Dermatologic Surgery of the Carolinas' Notice of Privacy Practices. This document is posted on our website and made available at our check-in desk. We would also be happy to provide you with a copy of this policy for you to take home with you.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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**How did you find us?**

Family/Friend - Name: \_\_\_\_\_  
Insurance Provider List  
Internet Search

Physician - Name: \_\_\_\_\_  
Other \_\_\_\_\_

Last Name: _____ First Name: _____ MI: _____ Previous Name: _____ (Maiden name, former married name, etc.) Mailing Address: _____ (if PO Box, complete <u>Home Address</u> below) City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Extension: _____	Primary Care Physician: _____ Referring provider: _____ Patient Date of Birth: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Do not wish to report Preferred Language: _____ Email: _____
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<p><b>Responsible Party (if different from patient above):</b> Statements will be mailed here. This does not change legal responsibility.</p> Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____ Email: _____ Relationship to patient: _____	<p><b>Adult Emergency Contact:</b></p> Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____ Alt. Phone: (____) _____ Relationship to patient: _____
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<p><b>HOME ADDRESS</b> (REQUIRED if PO Box given as mailing address):</p> Address: _____ City: _____ State: _____ Zip Code: _____	<p><b>PHARMACY INFORMATION:</b></p> Name: _____ Location: _____ Phone: (____) _____
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By signing below, I authorize Dermatologic Surgery of the Carolinas, LLC to leave messages in reference to any items that assist in carrying out healthcare operations.

Home phone:  Yes  No Cell:  Yes  No Work phone:  Yes  No Email:  Yes  No

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc):

Name: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient or Responsible Party **Signature** \_\_\_\_\_ Date \_\_\_\_\_



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### MEDICAL HISTORY

Patient \_\_\_\_\_ Appointment Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for visit: \_\_\_\_\_ How long has it been present? \_\_\_\_\_

Previous treatment? (Please list) \_\_\_\_\_

Please list any medications, herbal supplements and/or vitamins you are currently taking:  None

\_\_\_\_\_  
\_\_\_\_\_

Do you have or have you had any of the following? (if yes, please check)  None

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acne  | <input type="checkbox"/> Cold sores/herpes            | <input type="checkbox"/> Psoriasis                                   |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Seasonal allergies/asthma                   |
| <input type="checkbox"/> Artificial heart valve<br>(Year _____)              | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Skin Cancer (melanoma)                      |
| <input type="checkbox"/> Artificial joints or metal implant<br>(Year _____)  | <input type="checkbox"/> Heartburn/Reflux             | <input type="checkbox"/> Skin Cancer (basal/squamous cell carcinoma) |
| <input type="checkbox"/> Atopic Dermatitis/Eczema                            | <input type="checkbox"/> HIV                          | <input type="checkbox"/> Skin Pre-Cancers (actinic keratoses)        |
| <input type="checkbox"/> Atypical moles                                      | <input type="checkbox"/> Keloids or scarring problems | <input type="checkbox"/> Skin disorders (other)                      |
| <input type="checkbox"/> Autoimmune disease (lupus,<br>rheumatoid arthritis) | <input type="checkbox"/> Kidney disease               | <input type="checkbox"/> Systemic problems (fever/chill/etc.)        |
| <input type="checkbox"/> Bleeding disorder                                   | <input type="checkbox"/> Liver disease or hepatitis   | <input type="checkbox"/> Thyroid trouble                             |
| <input type="checkbox"/> Blood clots   | <input type="checkbox"/> Lung disease                 | <input type="checkbox"/> Ulcers (stomach)                            |
|  | <input type="checkbox"/> Muscle aches                 | <input type="checkbox"/> Other conditions                            |
|  | <input type="checkbox"/> Plastic/cosmetic surgery     | Please list: _____   |

Female patients (check all that apply): I am:  pregnant  nursing  planning to become pregnant soon

Are you allergic to any medications/anesthetics?  Yes  No  
(if yes, please list)

\_\_\_\_\_

Personal history of previous skin cancer?  Yes  No Location/When treated? \_\_\_\_\_

Please list other major illnesses: \_\_\_\_\_

Please list major surgeries/hospitalizations:

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

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

Please list IMMEDIATE FAMILY that have had any of the following (mother, father, maternal or paternal grandmother or grandfather, brother, sister):

- |   |   |
|---|---|
| <input type="checkbox"/> Skin Cancer-Melanoma: _____              | <input type="checkbox"/> Psoriasis: _____ |
| <input type="checkbox"/> Skin Cancer (Basal/Squamous cell): _____ | <input type="checkbox"/> Eczema: _____    |
| <input type="checkbox"/> Other Cancers: _____                     | <input type="checkbox"/> Other: _____     |

- |                                |  |   |  |
|--------------------------------|--|---|--|
| Do you smoke?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use sunscreen on a daily basis?        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use smokeless tobacco?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had at least one blistering sunburn? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drink alcoholic beverages?     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever used a tanning bed?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use recreational drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you currently use a tanning bed?           | <input type="checkbox"/> Yes <input type="checkbox"/> No |