



New Patient Information

Patient Name: _____ Ethnicity: _____ Age: _____ Sex: **M** **F**
 Address: _____ Language: _____ Date of Birth: _____
 City: _____ State: _____ Zip: _____ SSN _____ - _____ - _____
 Telephone: (H) _____ (W) _____ (C) _____ Occupation: _____

Employer: _____ Address: _____

Primary Insurance

Insurance Co. Name: _____ Phone: _____ Policy # _____
 Insurance Co. Address: _____
Street/P.O. Box City State Zip
 Insured's Name: _____ SSN: _____ DOB: _____ Relation: _____
 Insured's Employer: _____ Employer's Phone # _____

Secondary Insurance

Insurance Co. Name: _____ Phone: _____ Policy # _____
 Insurance Co. Address: _____
Street/P.O. Box City State Zip
 Insured's Name: _____ SSN: _____ DOB: _____ Relation: _____
 Insured's Employer: _____ Employer's Phone # _____

EMERGENCY CONTACT- Name: _____ Phone # _____
 Address: _____ Relationship: _____

Physician /Person who referred you: _____ Phone # _____
 Address: _____

Treatment and Financial Responsibility Statement

- A. I hereby request treatment by Academic Dermatology of Nevada. Such treatment may include testing and/or surgical procedures.
- B. I, (Guarantor/Patient) _____, accept responsibility to pay for all services rendered to me or (Patient/Minor) _____.
- C. In consideration of my relationship to the patient and of Academic Dermatology of Nevada, rendering medical services to said patient, I, _____ undertake to be financially responsible for and agree to pay, upon request, for all services rendered to the patient. I agree the obligation of the undersigned is an original, direct, independent, and positive promise to pay based on the executive credit of the undersigned and is not a collateral or contingent promise to answer the debt of another. In the event of default on payment due, I agree to pay all costs of collections including any attorneys fees and court costs.

Insurance Assignment

- A. This will authorize the filing of insurance claims on my behalf and assign payment directly to Curt Samlaska, M.D. for any and all amounts due for services provided in accordance with my insurance policy/policies.
- B. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Curt Samlaska, M.D. for any fees not covered by my insurance policy.
- C. I hereby authorize the release of information acquired in the course of the examination and/or treatment to my insurance carrier and/or my primary care physician as needed or required.

Signature of Guarantor/Responsible Party: _____

Date: _____ **Email Address:** _____



Name: _____ **Medical History Form**

Date of Visit: _____ **Date of Birth:** _____ **Age:** _____ **Gender:** M F
Reason for dermatology visit? _____

Medical Conditions

None **OR** Write "P" for Past and "C" for Current Problem (Use other* if problem not listed).

_____ Gout	_____ Heart Disease	_____ Bleeding Disorder	_____ Cancer Hx (history):
_____ Osteoarthritis	_____ High Blood Pressure	_____ Sickle Cell Trait / Disease	_____ Type: _____
_____ Rheumatoid Arthritis	_____ High Cholesterol	_____ Diabetes	Psychological Disorders:
_____ Osteoporosis	_____ Stroke	_____ Thyroid Disorder	_____ Depression
_____ Scoliosis	_____ Blood Clots / DVT	_____ Liver Disease	_____ Drug Abuse
_____ Fracture / Broken Bone	_____ Pulmonary Embolism	_____ Hepatitis	_____ Alcohol Abuse
_____ Cerebral Palsy	_____ Asthma	_____ Ulcers / Reflux	Other: _____
_____ Dementia	_____ Chronic Bronchitis	_____ Kidney Disease	_____ HIV / AIDS
_____ Neuropathy	_____ COPD	_____ Pregnant	_____ Hx Hepatitis: A B C
_____ Seizure Disorder	_____ Anemia	_____ Breastfeeding	Other: _____

List Drug Allergies & Reactions	Current Medications, None: <input type="checkbox"/>	List Past Surgery & Dates, None: <input type="checkbox"/>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

None **Family History**

Unknown/Adopted OR indicate if any of your blood relatives have had any of the following conditions

_____ Skin Cancer	_____ Eczema	_____ High Blood Pressure	_____ Kidney Disease
_____ Melanoma	_____ Rheumatoid Arthritis	_____ Respiratory Disease	_____ Depression
_____ Hay Fever / Allergy	_____ Osteoporosis	_____ Blood Disease	_____ Cancer:
_____ Atopic Dermatitis	_____ Muscle Disorders	_____ Bleeding Disorder	_____ Type: _____
_____ Psoriasis	_____ Heart Disease	_____ Diabetes	Other: _____

Social History

Tobacco Use:	Non Smoker: <input type="checkbox"/>	Alcohol Use:	Never: <input type="checkbox"/>	Marital Status:	Other:
_____ Former Smoker		_____ Rarely		_____ Single	_____
_____ Year Quit _____		_____ Weekly		_____ Married	_____
_____ Current smoker, # Pack/day _____		_____ Daily		_____ Divorced	_____
_____ # Years _____		_____ How much daily: _____		_____ Widowed	_____

Do you have an advance directive?no yes
 Are you a victim of violence or abuse?no yes
 Have you had a flu shot this year?no yes
 Have you had a pneumonia shot?no yes
 Have you been hospitalized for any reason?no yes

Name of Primary Care Provider if applicable: _____



Review Of Symptoms

Patient Name: _____ Date: _____

Name of Primary Care Provider (PCP): _____ Send letter to PCP? **No** **Yes**

PLEASE INDICATE BELOW. ARE YOU **CURRENTLY** EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional None:

Chills no yes
Fatigue no yes
Fever no yes
Night sweats no yes
Weight loss no yes

Eyes and vision None:

Difficulties/Vision no yes
Blurry or double vision no yes
Eye disease no yes
Glaucoma no yes

Ears, nose, throat None:

Nasal or mouth sores no yes
Nasal or mouth dryness no yes
Nose bleeds no yes
Hearing loss no yes
Ringing in ears no yes
Loss of smell no yes
Mouth and or gum disease no yes
Sore Throat no yes

Heart and Cardiovascular None:

Heart trouble or murmur no yes
Chest pains no yes
Sudden heartbeat changes no yes
Swelling of feet, ankles, hands no yes

Respiratory None:

Coughing or shortness of breath no yes
Sputum production no yes
Wheezing no yes
Coughing up blood no yes

Gastrointestinal None:

Nausea or vomiting no yes
Black or tarry stools no yes
Blood in stools no yes
Abdominal pain no yes
Change in bowel movements no yes
Constipation no yes
Diarrhea no yes

Endocrine None:

Hormonal problems no yes
Heat or cold intolerance no yes
Dry skin no yes
Swollen glands no yes
Excessive thirst no yes
Excessive urination no yes
Thyroid disease no yes

Musculoskeletal None:

Muscle pain or cramps no yes
Back pain no yes
Cold extremities no yes
Joint aches no yes
Difficulty walking no yes
Decreased joint range of motion no yes
Muscle pain or cramps no yes

Additional Skin History None:

Acne no yes
Dry lips no yes
Hair and nail changes no yes
Change in skin color no yes
Rash or itching no yes
Varicosities no yes
Breast lump, pain or discharge no yes

Neurologic None:

Frequent or recurrent headaches no yes
Light headed or dizzy no yes
Convulsions or seizures no yes
Numbness or tingling sensations no yes
Tremors no yes
Paralysis no yes
Stroke no yes
Head injury no yes

Psychiatric None:

Think of suicide no yes
Anxiety no yes
Depression no yes
Memory loss no yes

Hematology None:

Unusual bruising no yes
Blood clots no yes
Anemia no yes
Swollen glands no yes
Delayed healing no yes
Hepatitis exposure no yes
Bleeding problems no yes

Allergy history None:

Hay fever history no yes
Asthma no yes
Nasal congestion no yes
Food allergy no yes
Itching no yes

Patient sign here: _____

Date: _____



Skin Disease History

1. Do you wear Sunscreen? Yes, No If Yes, what SPF value: _____

2. Have you had any of the following:

Acne: Yes, No

Atypical Moles: Yes, No

Actinic Keratosis: Yes, No

Psoriasis: Yes, No

Basal Cell Carcinoma: Yes, No

Squamous Cell Carcinoma: Yes, No

Eczema, Flaking skin: Yes, No

Flaking Scalp, Dandruff : Yes, No

Poison Ivy History: Yes, No

Contact Dermatitis: Yes, No

Precancerous Moles: Yes, No

History of Melanoma: Yes, No

Hay Fever, Allergies: Yes, No

Sunburn History: Yes, No

Sunburns? How Many: _____

Other Skin Conditions: _____

3. Do you have family history of melanoma? Yes, No If so, who? _____

4. Do you or have you used tanning beds? Yes, No If Yes, how often: _____

5. When was your last skin check and where? _____

6. Are you interested in cosmetics (Example: Botox, Fillers, Ulthera, etc)? Yes, No

7. I am interested in the following cosmetic procedures: _____

8. If you have had cosmetic procedures performed, please list: _____

Date: _____ **Printed Name of Patient:** _____

Signature of Patient: _____

Practice Policies & SIGNATURE ON FILE

I hereby consent to and authorize all treatment that may be advisable or necessary. I will inform this office of any changes in my medical history, insurance coverage, telephone number an/or address as they occur. I certify this information is true and correct to the best of my knowledge.

I UNDERSTAND AND ACCEPT THAT I AM UNULTIMATELY FINANCIALLY RESPONSIBLE FOR ALL EXPENSES AND CHARGES INCURRED FOR SERVICES PROVIDED (REGARDLESS OF MY INSURANCE STATUS) AT ACADEMIC DERMATOLOGY OF NEVADA, 2839 St. ROSE PARKWAY, SUITE 100, HENDERSON, NV 89052.

PLEASE NOTE PAYMENT IS EXPECTED AND DUE AT THE TIME OF SERVICE FOR "YOUR PORTION" OF CHARGES; that includes and co-pays, co-insurance, any remaining deductible or certain cosmetic services. If you do not know the amount of your co-pay, 20% of the total charges will be collected at the time of service. For your convenience, we accept cash, personal checks with a check guarantee card (and driver's license) and VISA, MASTER CHARGE or DISCOVERY.

As a courtesy to our patients, we will bill your insurance company. In order to do so, we must have updated and accurate insurance information. If a completed claim form is required to accompany our bill, we must have that completed form at the time of your office visit. Please be aware that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your account with this office is your responsibility whether or not your insurance company pays.

We are preferred providers for most managed care organization; which means we have agreed to accept reduced reimbursement for our professional service. However, some insurers may use a variety of tactics to avoid, delay or inappropriately pay for our services, in addition to the already reduced ("contracted") fee schedule that we have agreed to. As your advocate, we will make every effort to obtain appropriate payment from your insurance company. However, if your insurance company has not paid your account in full or made any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill, (or we are unable to locate/notify you of your account status despite reasonable effort) you will be turned over to our collection agency. If your account is referred to a Collection Agency, you will be responsible for all Collection costs (40% or more of the amount owed), Attorney fees, Court costs, Service Fees & associated Miscellaneous Fees and Costs. An adult accompanying a minor patient (the "responsible party") is responsible for full payment of the minor patient's account.

Because of the quality of care that we provide for each of our patient, our practice is extremely busy. Please help us to better serve you by keeping all scheduled appointments. If you respectively (i.e. twice or more) fail to show for your appointments or cancel with less than 24 hours advanced notice, our policy is to charge \$50.00 for such missed appointments. There will be a \$50.00 charge for returned checks. Refunds of \$5.00 or less will not be refunded unless requested by the patient by phone or in writing.

I herein authorize payment of medical benefits to Curt Samlaska, MD, FACP, FAAD & Associates, LLC, when an assigned claim is filed. Further my signature authorizes Curt Samlaska & Associates, LLC to release any medical information necessary to process my insurance claims or as needed by my insurances (if any).

I authorize the use of this form on my insurance submissions, if needed. I permit a copy (of fax) of this authorization to be used in place of this original.

Please let us know if you have any questions or concerns. Our strict adherence to these policies serves to enhance our physician/patient relationship. My signature below indicates that I understand and accept these policies and obligations.

PRINT NAME: _____ **SSN:** _____

Date: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A DETAILED DESCRIPTION OF THIS PRIVACY PRACTICES NOTICE MAY BE FOUND IN THE MAGAZINE DRAWERS OF THIS WAITING ROOM.

This describes the type of information we gather about you, with whom that information may be shared and the safeguards we have put in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law, or permitted by law without your authorization. This notice describes practices of all of the persons and entities of Academic Dermatology of Nevada, regarding the use of your medical records.

1. Any health care professional of Academic Dermatology of Nevada, and all employees, staff and other personnel who may need access .
2. Keep confidential any medical information that concerns your condition/treatment, how your care is paid for and demographic information.
3. Give you this notice of our policies and procedures regarding privacy practices with respect to medical information about you.
4. Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations Purposes. We may use or disclose medical information about you for health care operations purposes. This is to make sure that all of our patients receive quality care.

Appointment Reminders. We may use and disclose information to contact you as a reminder that you have an appointment for treatment or medical care.

Individuals Involved in Your Care or Payment for Your Care. We may release information about you to a friend or family member who is involved in your care, with your permission. We may also give information to someone who helps pay for your care.

As Required by Law. We will disclose information about you when required to do so by federal, state or local law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Academic Dermatology of Nevada. All complaints must be submitted in writing only. You will not be penalized for filing a complaint. Please address your complaint to the office address listed above.

I hereby acknowledge that I have received and/or reviewed a copy of the Privacy Practices Notice.

Date: _____ **Printed Name of Patient:** _____

Signature of Patient: _____

I also authorize the following individuals to have access to my records:

Name	Relationship
_____	_____
_____	_____
_____	_____