Academic Dermatology of Nevada
The smart approach to skin disorders.

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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:** _____