PATIENT INFORMATION

653 N Town Center DR. #414

NAME (Last, First, Middle Initial): ______________________________
ADDRESS: ______________________________
CITY: ____________ STATE: ____________ ZIP CODE: ____________
HOME: (______) ____________ CELL: (______) ____________
DATE OF BIRTH: ____________ SOCIAL SECURITY #: ____________
E-MAIL ADDRESS: ______________________________
***By listing your e-mail address, you are consenting to e-mail notifications from Las Vegas Dermatology.**
STATUS: □ MARRIED □ SINGLE □ DIVORCED □ WIDOWED □ SEPARATED SEX: □ M □ F Height______ Weight: ______

EMPLOYER / SCHOOL INFORMATION
□ FULL TIME □ PART TIME □ STUDENT FULL TIME □ STUDENT PART TIME □ RETIRED □ NOT EMPLOYED
EMPLOYER/SCHOOL NAME: ______________________________
ADDRESS: ______________________________
CITY:____________ STATE: ____________ ZIP CODE:____________
PHONE #: ____________ OCCUPATION: ____________

HOW WERE YOU REFERRED TO US?
□ PHYSICIAN (NAME: LAST, FIRST): ______________________________
□ FRIEND / PATIENT (NAME: LAST, FIRST): ______________________________
□ INTERNET □ INSURANCE DIRECTORY □ YELLOW PAGES □ ADVERTISEMENT □ OTHER ____________

EMERGENCY CONTACT INFORMATION
NAME: ______________________________ SEX: □ M □ F
RELATIONSHIP TO PATIENT: ____________ PHONE: (______) ____________

PRIMARY INSURANCE
INSURANCE NAME: ______________________________
POLICY #: ____________ GROUP #:____________
POLICY HOLDER'S NAME: ____________ DATE OF BIRTH: ____________
ADDRESS: ______________________________
CITY:____________ STATE:____________ ZIP CODE: ____________
PHONE # :(_____) ____________ SOCIAL SECURITY #:____________ RELATIONSHIP:____________

SECONDARY INSURANCE
INSURANCE NAME: ______________________________
POLICY #: ____________ GROUP #:____________
POLICY HOLDER'S NAME: ____________ DATE OF BIRTH: ____________
ADDRESS: ______________________________
CITY: ____________ STATE: ____________ ZIP CODE: ____________
PHONE # :(_____) ____________ SOCIAL SECURITY #:____________ RELATIONSHIP: ____________

PREFERRED PHARMACY:______________________________
PHONE NUMBER: (_____) ____________ CROSS STREETS: ____________

ASSIGNMENT AND RELEASE, I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim in the course of my exam and treatment.

SIGNATURE ______________________________ **DATE** ____________

PH: 702-456-3120 FX: 702-823-1069 website: www.lvderm.com

ACKNOWLEDGEMENT SIGNATURE SHEET

I, ____ & ____ ,
(Patient's name) (Parent/Guardian's Name, if patient is a minor)
Acknowledge that I have reviewed:

1) HIPAA Disclosure Form
I hereby acknowledge that I reviewed this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.
Initial: ___________

2) Assignment of Insurance Benefits
I hereby acknowledge that this Medical practice's Assignment of Insurance Benefits. I hereby assign all medical and/ or surgical benefits. To include major medical benefits to which I am entitled, private insurance, and any other health plans, to Las Vegas Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
Initial: ___________

3) Medicare Financial Policy
I hereby acknowledge that I reviewed a copy of this medical practice's Financial Policy. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Financial Policy Practices at each appointment.
Initial: ___________
(MEDICARE Patients ONLY, this includes Medicare Advantage Plans)

4) Las Vegas Dermatology New Patient Financial Policy
I understand that there will be a $100.00 Booking Fee Deposit which will be applied towards copay or deductible at the initial visit, or refunded if there is no patient responsibility once processed.
Initial: ___________

5) Las Vegas Dermatology Financial Policy
I understand that if my account becomes delinquent it may be assigned to a third party collection agency. I understand that upon assignment of the account to a third party collection agency that an additional mark up of 35% will be added to the amount that I owe. I understand and agree to the adding of this collection fee. I agree to pay Las Vegas Dermatology for the services provided. Collection fees will be added if the account becomes 90 days delinquent.
Initial: ___________

6) Las Vegas Dermatology No Show/Cancellation Policy
If I have "No Showed" or cancelled within 24 hours of my appointment, I acknowledge that I, as the patient/patient's guardian, will be issued a $100 No Show Fee and will not be rescheduled until the fee is paid. If I am a Cosmetic patient who has "No Showed" or cancelled within 24 hours of my appointment, I will not be rescheduled without a non-refundable deposit of $150 each time I schedule in the future.
Initial: ___________

7) Authorization for Release of Medical Records and Billing Information
I hereby authorize the following people to have access to my medical records and billing information:

NAME	**RELATIONSHIP TO PATIENT**
____	______________________

SIGNATURE: ____ **DATE:** ______________________

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Patient History & Intake Form Pg. 1 of 2

Name:____ **Date of Birth:** ___________________________

Medication Allergies : (Please list drug and reaction)	
Drug:	Reaction:

Current Medications: (Please list name and frequency of use (i.e.: daily, twice daily)	
Medication:	Frequency:

Heart History: **(Please check all that apply)**

☐ Defibrillator
☐ Pacemaker
☐ Heart Valve Abnormality
☐ Blood thinners (i.e. Aspirin, Warfarin, Coumadin, Plavix)
Do You Need Pre-Medication? ☐ Yes ☐ No

Immunizations: **(Please list year if known)**

Tetanus:_____________ Shingles:_______________
Wart (Gardasil):_______________
Pneumonia Vaccine: _________________________

General Health History: (**Please check all that apply)**

Artificial Joints: ☐ Yes ☐ No
Date of last TB Test (year): ________________
Result: ☐ Positive ☐ Negative ☐ I have never had a TB test

Female Patients Only: **(Please check all that apply)**

Do you take oral contraceptives/ hormones?☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Trying to conceive? ☐ Yes ☐ No
Are your menses regular? ☐ Yes ☐ No
Have you had a hysterectomy? ☐ Yes ☐ No
Menopause? ☐ Yes ☐ No

Surgical History:	
Surgery:	Date:

Social / Family History:
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed
Occupation/ Profession?
Number of Children:
Do you smoke or chew tobacco? ☐ Yes ☐ No
Avg. number of alcoholic drinks per day:
Do you have any family history of: ☐ Melanoma ☐ None ☐ Other skin conditions: ________________________________

PATIENT OR GUARDIAN INITIALS: ______________________

Name:____ **Date of Birth:** ____________________________

Past Medical History:	
When was your last total body skin exam? Less than 1 year More than 1 year Never	
Do you have a personal history of: Pre-cancer Basal / Squamous Cell Carcinoma Melanoma None	
Please list any chronic illness or injury (such as diabetes, high blood pressure, etc.)	
1.	3.
2.	4.

Review of Systems: (Do you, or have you had, have any of the following conditions- if yes- please explain)

Y	N	
		Allergic Symptoms:
		Bleeding Problems:
		Breathing Difficulties / Respiratory Symptoms :
		Cardiovascular Problems or Chest Symptoms :
		Fever / Headache / Nausea / Dizziness :
		Endocrine Related Symptoms :
		Eye or Vision Problems:
		G.I. Symptoms:
		Urinary Symptoms:
		Immunologic Symptoms:
		Joint or Musculoskeletal Symptoms :
		Neurological Symptoms or Problems:
		Psychiatric or Emotional Difficulties:
		Skin-Related Symptoms:
		Ear / Nose / Throat / Mouth Symptoms:
		Do You Need Any Pre-Medication Before Procedures?:

Cosmetic: **Do you have any interest in cosmetic procedures or have you had any of the following procedures performed?**

(Please mark "P" for performed or "I" for interested) : ___Botox ___Fillers ___Wrinkle Therapy ___Mole Removal

___Blood Vessel/ Spider Vein Destruction ___Skin Tag Removal ___Laser Hair Removal

Reason(s) For Today's Visit/ Current Concern(s):
1)
2)
3)
4)

PATIENT OR GUARDIAN INITIALS: ________________________

Name____**Date**_________________________

We are excited to offer a variety of ***Cosmetic Services*** to our patients.
Please answer the questionnaire to help us provide you with information in your journey towards a
Healthier & more Beautiful Life.

What cosmetic procedures or products interest you (please check all that apply).

- ❑ Acne Treatment
- ❑ Botox Cosmetic/Dysport
- ❑ Dermal Fillers
- ❑ Excessive Sweating (Hyperhidrosis)
- ❑ Laser Hair Removal
- ❑Brown Spot Treatments
- ❑ Glycolic/Chemical Peels
- ❑ Latisse
- ❑ Microdermabrasion
- ❑ Microneedling/Skin pen
- ❑ Skin Rejuvenation
- ❑ Spider Vein Treatment
- ❑ Sun Damage
- ❑ Sunscreen Advice
- ❑ Skin Care Products
- ❑Laser Tattoo Removal
- ❑ Wrinkle Treatment

❑ Yes ❑ No Interested in a ***Skincare Consultation*?**
❑ Yes ❑ No Interested in a ***Make-up Education/Consultation?***
❑ Yes ❑ No Interested in having ***Longer, Fuller Lashes*?**
❑ Yes ❑ No Interested in options to reduce ***Razor burn, Ingrown hairs, and Shaving?***
❑ Yes ❑ No Interested in **Skin Resurfacing**?
❑ Yes ❑ No Interested in **Skin Tone and Texture Treatments**?
❑ Yes ❑ No Interested in **Red Spot/Blood Vessel/Spider Vein Treatments**?

Would you like to speak to our Medical Aesthetician **today** *about any of the above services?* ❑ Yes ❑ No

If our office held a ***Seminar*** for patients to learn more about certain cosmetic procedures and products, would you attend? ❑ Yes ❑ No
If yes, what day is best for you? ____

We offer ***Exclusive Specials*** by email only. Would you like to be placed on our mailing list to receive these specials? ❑ Yes ❑ No
If yes, what is your email address? ____
What would you like to change about your Skin?

____