LAS VEGAS DERMATOLOGY
for a healthier & more beautiful life

PATIENT INFORMATION

653 N Town Center DR. #414
Las Vegas, NV 89144

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: _____

PHARMACY NAME: _____ **CROSS STREETS:** _____
***Do you have an advanced care plan?** **Yes____** **No____**

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** _____

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ACKNOWLEDGEMENT SIGNATURE SHEET

I, _____ (*Patient's name*) & _____ (*Parent/Guardian's Name, if patient is a minor*),

Hereby acknowledge that I have reviewed:

1) HIPAA Disclosure Form

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

This medical practice's Assignment of Insurance Benefits. I hereby assign all medical and/or surgical benefits, including 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

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. ***(MEDICARE Patients ONLY, this includes Medicare Advantage Plans)***

Initial: _____

4) Las Vegas Dermatology® Financial Policy

We have an agreement with TSI Collections Agency regarding accounts that do not pay in a timely manner. We may attempt to notify you via text, email, mail, and/or phone about any overdue balances. In the event your account is sent to collections, a fee of $15.00 *minimum* will be added to your account and due by you along with the fees which you owe for services. Our goal is never to send anyone to collections. Please help us to do this by contacting our office if you are unable to pay your bill for any reason so we can discuss payment options with you.

Initial: _____

5) Las Vegas Dermatology® No Show 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 $50 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: _____

6) 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: _____

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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?