



## 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: \_\_\_\_\_



**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).

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

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

None **Family History**

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

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

**Social History**

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

**Eyes and vision** None:

Difficulties/Vision .....  
Blurry or double vision .....  
Eye disease .....  
Glaucoma .....

**Ears, nose, throat** None:

Nasal or mouth sores .....  
Nasal or mouth dryness .....  
Nose bleeds .....  
Hearing loss .....  
Ringing in ears .....  
Loss of smell .....  
Mouth and or gum disease .....  
Sore Throat .....

**Heart and Cardiovascular** None:

Heart trouble or murmur .....  
Chest pains .....  
Sudden heartbeat changes .....  
Swelling of feet, ankles, hands .....

**Respiratory** None:

Coughing or shortness of breath .....  
Sputum production .....  
Wheezing .....  
Coughing up blood .....

**Gastrointestinal** None:

Nausea or vomiting .....  
Black or tarry stools .....  
Blood in stools .....  
Abdominal pain .....  
Change in bowel movements .....  
Constipation .....  
Diarrhea .....

**Endocrine** None:

Hormonal problems .....  
Heat or cold intolerance .....  
Dry skin .....  
Swollen glands .....  
Excessive thirst .....  
Excessive urination .....  
Thyroid disease .....

**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**

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: \_\_\_\_\_

## 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 \$25.00 for such missed appointments. There will be a \$25.00 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 MAGAZINES 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 you 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
_____	_____
_____	_____
_____	_____