Front Desk Check-In

Initials _____

SUMMERLIN
DERMATOLOGY

Patient Information

Please Complete All Sections

Account # _____
(Office Use Only)

PT Initials _____ date _____
PT Initials _____ date _____
PT Initials _____ date _____
PT Initials _____ date _____
PT Initials _____ date _____

Name (First, MI, Last) _____ Date of Birth____/____/____ Age:____ Sex: M F
Mailing Address _____ _____ Apt # _____
City _____ State _____ Zip _____
Home Phone (____) _____ Daytime Phone (____) _____ Mobile Phone (____) _____
SS# _____Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widow(er) [ ]Separated
Email Address _____Would you like to receive emails from us? [ ]Yes [ ]No
Employer _____ Phone Number (____) _____
Employer Address _____
Name of referring physician (Primary Care Physician) _____ Phone Number (____)_____
List Family Members that are Patients _____

Parent or Responsible Party

(Applicable only for Minors)

Name (First, MI, Last) _____ Date of Birth____/____/____ Age:____ Sex: [ ]M [ ]F
Mailing Address _____ _____ Apt # _____
City _____ State _____ Zip _____
Relationship to Patient _____ SS# _____
Home Phone (_____) _____ Daytime Phone (_____) _____
Employer _____ Phone Number (_____) _____
Employer Address _____

Insurance Coverage-Primary

Name of Policy Holder (Insured) _____ Date of Birth____/____/____
Insurance Co. Name _____ Insurance Phone # (____) _____
Social Security # _____Policy Type: *(Please check one)* [ ] PPO [ ]EPO [ ]POS [ ]HMO [ ]GOV
ID# _____ Group/Policy # _____
Employer _____ Phone Number (____) _____
Employer Address _____
Patient's Relationship to Insured: *(Please check one)* [ ] Self [ ] Spouse [ ] Child [ ] Step-Child [ ] Other _____

Insurance Coverage-Secondary

Name of Policy Holder (Insured) _____ Date of Birth____/____/____
Insurance Co. Name _____ Insurance Phone # (____) _____
Social Security # _____Policy Type: *(Please check one)* [ ] PPO [ ]EPO [ ]POS [ ]HMO [ ]GOV
ID# _____ Group/Policy # _____
Employer _____ Phone Number (_____) _____
Employer Address _____
Patient's Relationship to Insured: *(Please check one)* [ ] Self [ ] Spouse [ ] Child [ ] Step-Child [ ] Other _____

Please turn form over and complete other side

Account # _____
(Office Use Only)

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Patient Information

Please Complete All Sections

Contact In Case of Emergency

Name of Emergency Contact _____
Relationship to Patient _____ Address _____
Day Phone# (_____) _____ Evening Phone# (_____)_____

Pharmacy Information

Pharmacy Name _____
Address _____
Phone Number (_____) _____ Fax Number (_____)_____

How did you hear about *Summerlin Dermatology*? *(Please check one)*

[ ] Newspaper [ ] Radio [ ] Magazine [ ] Doctor [ ] Family/Friend [ ] Yellow Pages [ ] Website [ ] Direct Mail [ ] Other: _____

Release of Information and Assignment of 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: Summerlin Dermatology, Reuel Aspacio MD. 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 that I am financially responsible for all charges not paid by said insurance. I hereby authorize said assignee to release all medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. _____ *(Initials)*

Payment Policy

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any ***applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.*** We accept payment in the form of cash, credit/debit with Visa/MC logo. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid by the insurance company. Prior authorization ***does not*** guarantee payment of claims. If a diagnostic procedure is performed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such a procedure. Your signature below signifies your understanding and willingness to comply with these policies. _____ *(Initials)*

A $30 ***"No Show"*** fee will be charged to your account if you fail to cancel or re-schedule your appointment at least ***24 hours*** in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment. Also, a $30 fee will be charged for any returned checks. _____ *(Initials)*

Insurance Coverage

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring it with you on the day of your visit. If you do not have a referral number, and your insurance requires it, it may be necessary to reschedule your appointment. I have read the Payment Policy and Insurance coverage described above. I understand and agree to all its provisions. _____ *(Initials)*

Written Acknowledgement Receipt of Privacy Practices Notice, Policy and Procedures

I, _____ *(Patient name or Responsible Party)*, have received a copy of ***Summerlin Dermatology***'s Notice of Privacy Practices including ***Summerlin Dermatology*** Office Policies and Procedures. _____ *(Initials)*

Patient or Responsible Party Signature: _____ Date: _____/_____/_____

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Medical Questionnaire

Name _____ Date _____ Date of Birth _____/_____/_____

Do you have or have you ever had any of the following?

Yes	No	
❑	❑	Skin Cancer / Melanoma
❑	❑	Acne
❑	❑	Cold Sores
❑	❑	Keloids / Bad Scars
❑	❑	Eczema / Skin Rashes
❑	❑	Difficulty with wound healing
❑	❑	Difficulty with skin infections
❑	❑	Psoriasis
❑	❑	Asthma / Hay fever / Hives / Sinus problems
❑	❑	Rheumatic Fever
❑	❑	Heart Disease
❑	❑	High blood pressure
❑	❑	Heart murmur / Mitral Valve Prolapse
❑	❑	Artificial Joint, heart valve, or prosthesis
❑	❑	Heart burn / Ulcers / Gastritis / Reflux
❑	❑	Kidney Disease
❑	❑	Glaucoma
❑	❑	Diabetes
❑	❑	Tuberculosis
❑	❑	Blood-borne Infections
❑	❑	Autoimmune disease (Lupus, rheumatoid arthritis)
❑	❑	Blood transfusions Dates: _____
❑	❑	Hepatitis – B or C (please circle)
❑	❑	HIV/AIDS
❑	❑	Surgery/Hospitalizations

Operation Date Hospital

_____

_____

❑ ❑ Other _____

_____

_____

Have any blood relatives ever had any of the following?

❑	❑	Skin Cancer
❑	❑	Melanoma
❑	❑	Abnormal moles
❑	❑	Asthma / Hay fever
❑	❑	Eczema / Skin Rashes
❑	❑	Diabetes
❑	❑	Psoriasis
❑	❑	Other skin disease _____

Signature: _____

Revised 3/5/10

Are you allergic to any medications?

(Please list) If None, check here ❑

_____

_____

_____

_____

Are you currently taking or using any medications or vitamin/mineral supplements?

(Please list) If None, check here ❑

_____

_____

_____

_____

Other Questions	**Yes**	**No**
Are you currently taking Accutane or have you used Accutane in the past?	❑	❑
Are you in good health?	❑	❑
Are you now under a physician's care?	❑	❑

If so, for what conditions?

_____

_____

_____

Name of your primary care physician

_____

	Yes	**No**
Do you smoke?	❑	❑
Do you Drink?	❑	❑
Do you sunbathe or use tanning booths?	❑	❑
Do you need antibiotics before surgery or Dental work?	❑	❑
Do you bleed easily for a long time after a cut or extraction?	❑	❑
Do you use sunscreen?	❑	❑
Females only		
Are you pregnant?	❑	❑
Are you nursing?	❑	❑
Do you take birth control pills?	❑	❑
Name of birth control pills_____		
Date of last menstrual period ____/____/____		
Men only		
Do you have penile discharge	❑	❑
Do you have sores on penis	❑	❑

DATE PROVIDER REVIEWED:	**PROVIDER INITIALS:**
_____	_____

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DERMATOLOGY
Reuel M. Aspacio M.D.
8310 W. Sahara Ave
Las Vegas, NV 89117
Phone (702) 243-4501
Fax: (702) 243-4701

♦♦♦♦♦♦♦♦

Patient Consent for Medical Photography

Patient Name: _____ Date: _____

☐ **Check here if minor or unable to provide consent.**

☐ **I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purpose of medical teaching, or the publication in medical textbooks or journal as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. However, the tracking of patient progress may be inhibited.**
If I have any questions or wish to withdraw my consent in the future I may contact:

Summerlin Dermatology
Attention: Administrator
Call 702.243.4501
or
e-mail: info@summerlinderm.com

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

☐ **I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientist and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.**

Patient Signature: _____ Witness: _____

☐ **I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR Medical Publication:**

Patient Signature: _____ Witness: _____

☐ **I do not consent to any of the above.**

Patient Signature: _____ Witness: _____

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above:

Patient Signature or Legal Guardian: _____ Date: _____

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Written Acknowledgement Receipt of

Privacy Practices Notice

I, (Patient name or Responsible Party) _____, have received a copy of Summerlin Dermatology's Notice of Privacy Practices.

PROTECTED HEALTH INFORMATION AUTHORIZATION

Please allow access of my Protected Health Information (PHI) to:

Person's name Relationship

_____ /_____

_____ /_____

_____ /_____

Signature: _____

Print Name: _____ Date: _____

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Reuel Aspacio, M.D.

Patient Consent to Leave Detailed Message/Information

Dear Patient:

Summerlin Dermatology has adopted a policy that requires our staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect our staff from violating the patient's confidentiality. If we do not have a signed consent on file, the staff may only leave their name and a phone number on an ***answering machine*** asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give consent to Dr. Aspacio and/or the staff of Summerlin Dermatology to leave a message regarding treatment, test result or other necessary information.

Please print phone numbers on the line(s) below:

1. _____ On an answering machine at home
   (Home Phone Number)
2. _____ On cell phone voice mail
   (Cell Phone Number)
3. _____ On voice mail at work
   (Work Number)
4. _____ On e-mail message
   (E-Mail Address)

_____ _____
Patients Signature Date

.....

I do **NOT** consent to any messages being left on message other than the office name, staff member name and phone number.

_____ _____
Patients Signature Date

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Cosmetic Interest Questionnaire

Patient Name: _____ Date: _____

Email Address: _____

Health issues and procedures or products of interest to you (please check all that apply).

- □ BOTOX® Cosmetic (Botulinum Toxin Type A)
- □ Excessive Sweating (Hyperhydrosis)
- □ Collagen Therapy
- □ Skin Rejuvenation
- □ AHA and Glycolic Peels
- □ Acne, Sun Damage
- □ Microdermabrasion
- □ Chemical Peels
- □ Laser Resurfacing
- □ Laser Treatments
- □ Body Contour
- □ Skin Care Advice
- □ Skin Care Products
- □ Birthmarks
- □ Liver Spots/Age Spots
- □ Sunscreen Advice
- □ Removing Leg Veins
- □ Facial and Eye Treatments
- □ Hair Removal
- □ Spider Vein Treatments
- □ Removing Facial Veins
- □ Scar Treatment
- □ Other, please specify _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

□ My physician (full name) _____
□ My insurance company (name)_____
□ The yellow pages (specific advertisement)_____
□ A friend or family member (name)_____
□ Another person not listed above (name)_____
Please provide the name of and address of the person who referred you so we can thank them
_____
□ Internet (website) _____
□ A seminar where I saw the doctor. The event took place on (date) _____
at (location)_____

□ Approval to Send Information

_____
Patient Signature Date