WELCOME

❑ New Patient / ❑ Name or ❑ Address or ❑ Insurance Change / ❑ Other change

Thank you for selecting our practice! So that we may best serve you, please fill out this form as accurately as possible and return it to our receptionist. If you have any questions or need assistance, please ask us – we will be happy to help. Thank you.

PATIENT INFORMATION (Please Print) **CONFIDENTIAL** Date_____

Name_____ Home Phone (_____)_____

Mailing Address_____ Mobile (Cell) # (_____)_____

City_____ State_____ Zip _____

Alternate Address (if part-time resident)_____

Birthdate_____ Age _____ Gender: ❑ Male ❑ Female

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Social Security Number_____

Patient's Employer_____ Work Phone (_____)_____

Business Address_____

City_____ State_____ Zip_____

If Student, Name of School/College_____ City_____State_____

May we contact you via email? If yes, Email address:_____

May we contact you via ❑ Home or ❑ Work Fax? If yes, Fax #:_____

Person to contact in case of EMERGENCY_____ Phone _____

(Emergency Contact's) Relationship to patient_____

Who/What referred you to our Office? ❑ Doctor ❑ Patient ❑ Yellow Pages ❑ Internet/Website/Search ❑ Other

Name_____ Phone Number_____

Address_____ Fax Number_____

Website or Search Engine or other referral source_____

***Do you or have you ever written / posted online reviews on**: ❑ Yelp ❑ Angie's List ❑ RealSelf ❑ Other_____

Medical Doctor_____ Phone #_____/ Fax #_____

Address_____ Date last seen by this physician_____

RESPONSIBLE PARTY / Name of Insured (if different than Patient)

Name of Person responsible for this account _____ Birthdate_____

Relationship to Patient_____ Social Security Number_____

Address_____ Home Phone (_____)_____

Alternate Address (if part-time resident)_____

Driver's License # (& State)_____ Financial Institution_____

Employer_____ Work Phone (_____)_____

Address of Employer_____

Date employed_____ Is this person a patient of our office? ❑ YES ❑ NO

May we contact you via email? If yes, Email address:_____

INSURANCE INFORMATION - Primary

Name of Insured_____ Birthdate_____

Insurance Co. Name_____ Phone # (_____)_____ Ext. _____

Policy or Id Number_____ **Group Name or #**_____

Policy Type: ❑ PPO ❑ POS ❑ HMO ❑ Other _____

Union or Local #_____

Insurance Co. Address_____

City_____ State_____ Zip_____

How much is your Co-payment for Office visits?_____ How much is your Co-Insurance, if any?_____

How much is your Deductible?_____ And how much have you used?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE – Secondary Insurance? ❑ YES ❑ NO

If yes, complete the following:

Name of Insured_____ Birthdate_____

Relationship to Patient_____ Social Security Number_____

Employer_____ Work Phone (_____)_____

Address of Employer_____

Date employed_____ Is this person a patient of our office? ❑ YES ❑ NO

Insurance Co. Name_____ Phone # (_____)_____ Ext. _____

Policy or Id Number_____ **Group Name or #**_____

Policy Type: ❑ PPO ❑ POS ❑ HMO ❑ Other _____

Union or Local #_____

Insurance Co. Address_____

City_____ State_____ Zip_____

How much is your Co-payment for Office visits?_____ How much is your Co-Insurance, if any?_____

How much is your Deductible?_____ How much have you used?_____

The above listed contact information shall be used to notify you of personal health information, including billing and past due charges among others, Also, should we need to communicate such info to you, and you are not immediately available via one of your listed contacts, we will provide this information to one of your immediate family members (i.e. spouse or significant other, adult age children and parents) or care-taker/s (via contact information you provide us on this form) unless you specify otherwise in writing here or revoke in the future via certified written letter.

Please document any specific alternative directions here_____

_____

Also, please provide us with any contact name, relationship, info, not already listed, for those approved to receive your personal health information:

_____

X_____ Date_____

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY

For Office Use Only:

❑ Attach a copy of patient's drivers license (or other form of Id) Staff Initials_____

❑ Attach a copy of patient's insurance card or cards (front and back) Staff Initials_____

❑ Verify this form is filled out completely, front and back Staff Initials_____

ROBERT B. STRIMLING, MD and Associates, LLC
Practice Limited to Dermatology, Dermatologic/MOHS Surgery,
& Cosmetic & Laser Surgery

Summerlin Hospital Complex, Medical Office Building III
10105 Banburry Cross Dr., Suite 350
Las Vegas, NV 89144 (702) 243-6400

Practice Policies, Disclosures & SIGNATURE ON FILE

I hereby give my consent to and authorize medical examination and all treatment that may be advisable or necessary, including routine dermatologic procedures, such as biopsy or removal of minor skin lesions or treatment with liquid nitrogen, which will be explained in detail before treatment; and the following:
(Our doctors usually perform pathologic interpretations for any skin lesions removed; typically 3-7 days after the office visit, which incurs a separate charge. On occasion, the doctor at his discretion may feel that a second opinion is warranted and if so, another separate charge will be incurred from an outside lab.)
This above consent shall apply to all office visits, now and in the future, unless I revoke this authorization via written certified letter.
Furthermore, I will inform this office of any changes in my medical history, insurance coverage, telephone number and/or address as they occur; and periodically, verify (with office staff) that my above information on record is accurate. I certify this information is true and correct to the best of my knowledge.

I UNDERSTAND AND ACCEPT THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR ALL EXPENSES INCURRED FOR SERVICES PROVIDED REGARDLESS OF MY INSURANCE STATUS. AND I GIVE CONSENT TO BE CONTACTED VIA ANY OR ALL CONTACT INFO THAT I HAVE PROVIDED.

PLEASE NOTE - PAYMENT IS EXPECTED AND DUE AT THE TIME OF SERVICE FOR "YOUR PORTION" OF CHARGES;
that includes any co-pays, co-insurance, any remaining deductible and non-covered or cosmetic services, as we do not regularly bill patients for these charges.
Please note it is your responsibility to know your co-pay, co-insurance, deductible and other pertinent plan specifics and to update us with this information regularly.
If you (or we) 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 check with valid identification (i.e. driver's license), and VISA / MASTER CARD / AMEX / DISCOVER.
Any credit card surcharge that may apply will be disclosed. Refunds by credit card incur a 3-5% processing fee. You will be charged $25.00 for all returned checks.
If copies of records are requested, there is a $15.00 minimum handling fee plus $.60 per page or otherwise as determined by law.

Please note that we bill your insurance as a **courtesy**. In order to do so, we must have updated and accurate insurance information.
If a completed claim form is required to accompany our billing, then 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 will bill your insurance at least one time. If you have not received notification from your insurance company that we have been paid within 45 days of your date of service, we ask that you please contact your insurance company to check the status of your claim!!!

Although we are preferred providers for most managed care organizations; and thus, have agreed to accept reduced payment for our professional services; some insurers may use a variety of tactics to avoid, delay or improperly pay for our services, in addition to our agreed upon reduced ("contracted") fee schedule. As your advocate, we will make a reasonable effort to obtain appropriate payment from your insurance company. However, if your insurance company has not paid your bill properly, in full (per contracted fees) within 90 days from the date of service, any balance will be due and payable by you, regardless of whether or not your insurance company states otherwise. You will only be responsible for our determined contracted fee for each service provided.
Also, you acknowledge here that we will inform you and obtain your approval prior to providing any known non-covered services, e.g. cosmetic services. Furthermore, we cannot anticipate if your insurer will deny a service as non-covered that is usually considered covered. (Although, some insurers may use this tactic to avoid payment; you also agree to be responsible for our charges related to such services, despite any contrary rhetoric your insurer may claim.)

In the event your account becomes past due, your balance will accrue interest at the rate of 1% per month (i.e. 12% per annum).
A past due account is an account not paid within 30 days from our 1st date of billing you.
In the event that you fail to pay in full or make 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) your balance will be turned over to our outside office Collection Agency.
A $50 charge will be assessed to all collections accounts, in addition to any accrued interest. If your account is referred to our Collection Agency, interest will continue to accrue at the rate noted herein. In addition, you will be responsible for all added percentage based Collection fees / costs per our prevailing collection company contract, Attorney fees, Court Costs, Administrative / 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.

Please help us serve you better by keeping all scheduled appointments. Otherwise notify us as soon as possible if you are unable to keep your appointment.
If you fail to show for your appointment or cancel less than 24 hours prior your appointment, our policy is to charge you $25 for such missed appointments.
Also, we charge $25 per form to complete FMLA, disability, "Cancer Insurance Policy" forms or other similar forms, payable prior to completing such form(s).
We will retain your medical records for 5 years per NRS (Nevada Law), after which they may be destroyed unless legally required otherwise.

I herein authorize payment of medical benefits to Robert B. Strimling, MD & Associates, LLC, when an assigned claim is filed.
Also, my signature authorizes Robert B. Strimling, MD & Associates, LLC to release any medical information necessary to process my insurance claims.
Furthermore, my signature here acknowledges that Robert B. Strimling, MD and Associates, LLC has informed me that they have a Notice of Privacy Practices (which describes how medical information about me may be used and disclosed and how I can get access to this information) as in compliance with HIPAA.

I will not post a negative review online without first notifying management &/or doctors of my intent to do so and permitting management the opportunity to reconcile my issues.
Please let us know if you have any questions or concerns. Adherence to these policies enhances our relationship. My signature below indicates I understand and accept these policies.

PRINT NAME_____ SS #_____

_____ DATE_____

Signature of Patient or Legal Guardian

NAME:_____ Date_____
Birthdate_____ Age_____ Occupation_____

MEDICAL HISTORY: Please describe the main reason(s) for your visit/referral:
(For each condition, if possible or pertinent, please include how long you have been afflicted,
whether or not the condition is symptomatic (e.g. itchy or painful),
any perceived aggravating or alleviating factors, past and current treatment(s)
and whether treatment(s) was/is successful and any other current possibly related conditions)

_____
_____
_____
_____
_____

Are you ALLERGIC to any medications? ❑ YES ❑ NO
If YES, please indicate which one(s):_____

Are you ALLERGIC to any foods? ❑ YES ❑ NO
If YES, please indicate which one(s):_____

Are you ALLERGIC to any other environmental exposures? ❑ YES ❑ NO
If YES, please indicate which one(s):_____

Please list all MEDICATIONS that you are currently taking, (including birth control pills,
over the counter medications and any medications that you take occasionally).

_____
_____
_____

How much ALCOHOL do you consume in a week?_____
How much TOBACCO do you consume in a week?_____
Have you traveled out of state recently? ❑ YES ❑ NO
If YES, where_____

Do you have any first degree relative(s) with any inherited skin conditions? ❑ YES ❑ NO
If YES, which relative(s), age of onset, what condition(s)_____
or skin cancer? ❑ YES ❑ NO
If YES, which relative(s), age, what type(s)_____
Do other family members have skin problems now or in the past? ❑ YES ❑ NO
If yes, which family member(s) and describe problem(s):_____
_____
Please indicate any other diseases/conditions of your first degree relatives.
Parents (Father & Mother):_____
Siblings:_____
Children:_____

When exposed to sunlight, do you: ❑ Burn ❑ Burn-Tan ❑ Tan
Have you ever had a skin cancer? ❑ YES ❑ NO
If YES, what type(s), location(s), treatment method(s), and year(s) treated:
_____
Do you have a personal history of any specific skin diseases? ❑ YES ❑ NO
If YES, please list_____
_____

Do you have or have you been previously diagnosed with, treated for or received any of the following:

	YES	NO		YES	NO
Recent Fever	❑	❑	X-ray or Radiation Treatments	❑	❑
Recent significant Weight Loss	❑	❑	PUVA or UVB	❑	❑
Heart Disease	❑	❑	Diabetes	❑	❑
High Blood Pressure	❑	❑	Glaucoma	❑	❑
Angina/Chest pain or Heart Attack	❑	❑	Hepatitis or Yellow Jaundice	❑	❑
Heart Rhythm Disturbance	❑	❑	Blood Transfusions	❑	❑
Pacemaker	❑	❑	IV or Recreational Drug Use	❑	❑
Stroke / TIA / Carotid artery disease	❑	❑	AIDS or HIV	❑	❑
Seizure or Epilepsy	❑	❑	Problems Healing	❑	❑
Bronchitis or Emphysema	❑	❑	Excessive Scarring	❑	❑
Hay Fever or Asthma	❑	❑	Liver Disease	❑	❑
Other Breathing Difficulty	❑	❑	Kidney or Bladder Disease	❑	❑
Chronic or Morning Cough	❑	❑	Intestinal colitis or Chron's dis.	❑	❑
Bleeding Disorder	❑	❑	Other Stomach/Bowel Disease	❑	❑
Cold Sores or Fever Blisters	❑	❑	Thyroid Disease	❑	❑
Heart Murmur	❑	❑	Rheumatoid Arthritis	❑	❑
Mitral Valve Prolapse	❑	❑	Lupus erythematosus	❑	❑
Artificial joint	❑	❑	Scleroderma	❑	❑
Phlebitis (Inflammation of vein/s)	❑	❑	Other Collagen-vascular dis.	❑	❑
Blood clots (esp, deep vein or lung/s)	❑	❑	Vision &/or hearing deficits	❑	❑
Peripheral vascular disease	❑	❑	Nasal symptoms / sore throat	❑	❑
Dizziness or Fainting	❑	❑	Abdominal pain	❑	❑
Emotional Problems	❑	❑	Urinary discomfort	❑	❑
Chronic fatigue	❑	❑	Muscle &/or joint pain	❑	❑

(Women) Are you currently **PREGNANT** or **NURSING**? ❑ ❑
or are you trying to get **PREGNANT**? ❑ ❑

Are your Vaccinations/Immunizations up to date? ❑ ❑
Do you take antibiotics routinely before dental check-ups or surgery? ❑ ❑
Other Illnesses/injuries/conditions?_____
_____
Please list previous hospitalizations/surgeries including year and reason:_____
_____

If you are here for a COSMETIC Surgery Consultation, please also answer the following questions:
Do you use or have you ever used any of the following products:
❑ Retin-A, Renova, or Tretinoin (What type/strength_____)
❑ Alpha-hydroxy acid or glycolic acid product (Which one(s)?_____)
❑ Hydroquinone product (Bleaching or fading cream) (Which one(s)/how long?_____)
Any other product(s) that you think we should know about?_____
❑ Accutane (Isotretinoin)/Sotret/Amnesteem/Claravis or Soriatene (Please describe use history_____
_____)

Have you been previously diagnosed with, treated for or received any of the following:

	YES	NO		YES	NO
Restylane / Silk / Lyft / Refyne / Defyne	❑	❑	Dry eyes	❑	❑
JuveDerm / Voluma / Vobella / Vollure	❑	❑	Eye disease or surgery	❑	❑
Bellafill / Radiesse / Sculptra	❑	❑	Neuromuscular disease	❑	❑
Facial Electrolysis	❑	❑			

Please list previous Cosmetic surgeries or procedures not already mentioned (Type, When, by Whom):
_____
_____

SIGNATURE_____ DATE_____