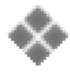


Thomas Dermatology

General and Pediatric Dermatology
MOHS Surgery and Cosmetic Dermatology

To Our Valued Patients:

We apologize in advance for the increased paper work, specifically the "bubble sheets", you are required to fill out.

As mandated by the Federal Government, we are in the process of converting our manual records to EMR (Electronic Medical Records). Ironically, going paperless may initially require increased paperwork for some of our patients.

Although EMR will lead to better medical care in the future, we understand that the benefit is hard to see while you are filling out all of this paper work.

Please know that we sympathize with you, and assure you that your turn to see the Provider will not be delayed because of the time you take in filling out the required information.

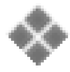
We thank you in advance for your cooperation and understanding. In the future you may choose to update your information via our patient portal found on our website at www.thomasderm.com

Sincerely,

Thomas Dermatology

How to activate your portal:

- **You will receive an email shortly after your appointment with your username and password to set up your account.**
- **When you enter your portal, go to messages and click on "Ask Doctor."**
- **Enter "Activate Portal" in the subject line, type your name in the message, and submit.**
- **Now you can manage your upcoming appointments, contact a nurse, and view medical records.**



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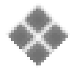
***Patient Name:* ____ Height _______ Weight _______DOB_______**

Please (X) in yes if you are currently experiencing any of these conditions.

Condition	
Fever	O Yes
Chills	O Yes
Fatigue	O Yes
Night sweats	O Yes
Cough	O Yes
Runny Nose	O Yes
Sneezing	O Yes
Chest pain	O Yes
Shortness of breath	O Yes
Dizziness	O Yes
Easy bruising	O Yes
Easy Scarring	O Yes
Headache	O Yes
Abdominal pain	O Yes
Nausea	O Yes
Constipation	O Yes
Diarrhea	O Yes
Joint pain	O Yes
Muscle aches	O Yes

Social History :* *Please (X) in the correct answer if it applies to you.

Question			
Do you smoke?		O Yes	O No
Do you drink alcohol?		O Yes	O No
Do you use sunscreen?		O Yes	O No
Have you had at least 1 blistering sunburn in your lifetime?		O Yes	O No
Have you ever utilized a tanning bed?		O Yes	O No
Do you work indoors or outdoors?	O Indoors	O Outdoors	O Retired



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Patient Name:____ **DOB________________**

Please (X) in yes if you have any of these conditions or have had a history of them.

Internal cancer- Please note type	O Yes
History of Basal Cell Carcinoma	O Yes
History of Squamous Cell Carcinoma	O Yes
History of Melanoma	O Yes
Atypical nevi/Abnormal Moles	O Yes
Actinic Keratosis/Precancerous Lesions of the Skin	O Yes
Eczema/Dry Skin Conditions	O Yes
Allergies/Hayfever	O Yes
Asthma	O Yes
Food allergies	O Yes
Psoriasis	O Yes
Keloids/ Thick Scars	O Yes
HIV	O Yes
Hepatitis B	O Yes
Hepatitis C	O Yes
Tuberculosis	O Yes
Diabetes	O Yes
COPD/Chronic Obstructive Pulmonary Disease	O Yes
Rheumatoid Arthritis	O Yes
Other Autoimmune disorder	O Yes
Thyroid Disorder	O Yes
Lupus	O Yes
High Blood Pressure	O Yes
High Cholesterol	O Yes
Heart disease	O Yes

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Patient Name: **____ DOB_______________**

Psychiatric Conditions (e.g. Depression, Bipolar disorder, Schizophrenia) O Yes

Neurologic Disease (e.g. Parkinson's, Multiple Sclerosis) O Yes

Surgical History- Please (X) in yes if you have had any of these surgeries.

Mohs Surgery or Skin Cancer Surgery O Yes

Organ Transplant-Please specify O Yes

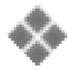
Hysterectomy O Yes

Artificial Heart Valve O Yes

Pacemaker O Yes

Artificial joints - Please Specify and Note Year ______ O Yes

Please note or advise the back office staff if there are any other surgeries that you have had that are not listed above.



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PATIENT HISTORY

PATIENT NAME: ____

REFERRING DR: _______________________________PRIMARY CARE DR: ______________________________

(First and Last) (First and Last)

PHARMACY HEALTH INFORMATION

PLEASE BRING A LIST OF ALL MEDICATIONS THAT YOU MAY BE TAKING AND STRENGTH OF MEDICATION

PHARMACY NAME:		PHARMACY STORE PHONE NUMBER:
PHARMACY CROSS STREET:		
LIST OF MEDICATIONS:	**REASONS FOR USE:**	**VITAMINS/HERBS/SUPPLEMENTS:**
		Females only:
		Are you pregnant? Y N
		Are you nursing? Y N
		ALLERGIES TO THE FOLLOWING
MEDICATION ALLERGIES:	**REACTION:**	TOPICAL ANTIBIOTICS YES OR NO (i.e. POLYSPORIN, NEOSPORIN)
		LOCAL ANESTHETICS YES OR NO
		TAPE YES OR NO
		LATEX YES OR NO
		Do you need antibiotics before surgery or dental work? Y N
Family History of :		**HOW DID YOU HEAR ABOUT US?**
Eczema	Y N	Physician Referral Phone Book
Asthma	Y N	Friend Insurance Carrier
Allergies/Hayfever	Y N	Family Member Other
Hives	Y N	Internet Search Engine- ______________________
Skin Cancers If yes, what type:	Y N	Ex: Google, Yahoo, Angies List, Dex, MSN, etc

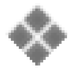
Would you like a FREE skincare consultation with our Skin Specialist to learn about products we carry? (Obagi, Revision, Latisse) ***Y N***

Would you like a FREE consultation with one of our Aestheticians, Sabina or Reylina, to learn about the Aesthetic procedures we offer? (Facials, Laser Hair Removal, Microdermabrasion, etc.) ***Y N***

Would you like to schedule a time to discuss Cosmetic Procedures (Laser Treatments, Botox, Dysport, Radiesse, Sculptra, etc.) with your Provider? ***Y N***

I, the undersigned, do hereby authorize my insurance carrier(s) to pay directly to Thomas Dermatology the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including copay and/or deductible amounts. I, the undersigned, do hereby also give my permission to Thomas Dermatology to furnish my insurance carrier(s) any and all information pertaining to my medical records.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON _________________________________**DATE**______________



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PATIENT INFORMATION (PLEASE PRINT)

PATIENT NAME:		Date of Birth:	AGE:	SEX: M / F	MARITAL STATUS:
HOME ADDRESS:			CITY, STATE AND ZIP		
HOME PHONE #	CELL PHONE#		SS#		EMPLOYER/OCCUPATION:
SPOUSE NAME:		Date of Birth:	AGE:	SEX: M / F	EMPLOYER/OCCUPATION:
CELL PHONE #:	SS#				

RESPONSIBLE PARTY OF INSURANCE

PRIMARY INSURED NAME:	Date of Birth:	SS#	SEX: M / F
HOME ADDRESS:		CITY, STATE AND ZIP	
PRIMARY INSURANCE CO:		POLICY #	GROUP #
SECONDARY INSURED NAME:	Date of Birth:	SS#	SEX: M / F
HOME ADDRESS:		CITY, STATE AND ZIP	
SECONDARY INSURANCE CO:		POLICY #	GROUP #

INSURANCE INFORMATION (PLEASE BRING CARDS TO APPOINTMENT)

PARENT INFORMATION IF PATIENT IS A MINOR

No need to fill in the address if it is the same as the patient

MOTHER'S NAME:	Date of Birth:	SS#	PHONE #:
HOME ADDRESS:		CITY, STATE AND ZIP	
FATHER'S NAME:	Date of Birth:	SS#	PHONE #:
HOME ADDRESS:		CITY, STATE AND ZIP	

PLEASE CIRCLE ONE THAT BEST FITS:

PATIENT RACE: AMERICAN INDIAN, ALASKA NATIVE, ASIAN, NATIVE HAWAIIAN, OTHER PACIFIC, AFRICAN AMERICAN, CAUCASIAN, HISPANIC, OTHER, REFUSE TO REPORT

PATIENT ETHNICITY: HISPANIC OR LATIN, NOT HISPANIC OR LATIN, REFUSE TO REPORT

LANGUAGE: ENGLISH, SPANISH, RUSSIAN, INDIAN, OTHER

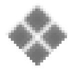
PATIENT E-MAIL: ______________________________

NEAREST FRIEND/RELATIVE (NOT LIVING WITH YOU) NAME: ______________________________

ADDRESS:______________________________**PHONE NUMBER:** ______________________________

RELATIONSHIP: ______________________________

SIGNATURE OF PATIENT OR AUTHORIZED PERSON ______________________________**DATE**______________



Thomas Dermatology

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FINANCIAL POLICY

Thank you for choosing the physicians and staff at Thomas Dermatology as your healthcare providers. Our mission is to provide the highest quality dermatologic care - every patient, every appointment, every day.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which you are required to read and sign prior to treatment.

- **ALL PATIENTS MUST COMPLETE OUR PATIENT INFORMATION, PATIENT HISTORY, AND HIPAA POLICY FORMS BEFORE SEEING A PROVIDER.**
- **CURRENT INSURANCE CARDS AND A PHOTO ID MUST BE PRESENTED AT CHECK-IN TO BE SCANNED INTO OUR SYSTEM. IF THOMAS DERMATOLOGY AGREES TO SEE PATIENT WITHOUT CURRENT INSURANCE CARDS, THE PATIENT AGREES TO ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THE APPOINTMENT AND ANY INSURANCE BILLING COMPLICATIONS THAT MAY ARISE DUE TO LACK OF UPDATED INSURANCE INFORMATION.**
- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR CASH PATIENTS, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**
- **CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE PAYMENTS ARE DUE AT TIME OF CHECK-OUT FOR INSURED PATIENTS.**
- **WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER, AS WELL AS DEBIT CARDS.**
- **ANY BALANCE DUE FROM PRIOR VISITS MUST BE PAID PRIOR TO ANY SUBSEQUENT VISIT.**
- **ALL ACCOUNTS 90 DAYS PAST DUE WILL BE AUTOMATICALLY ASSIGNED TO A COLLECTION AGENCY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**
- **IF THE ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, PATIENT AGREES TO PAY ALL EXPENSES OUR PRACTICE MAY INCUR IN COLLECTING THE DELINQUENT BALANCE. COLLECTION FEES ARE BETWEEN 40% AND 50% OF THE BALANCE OWING, AND WILL BE DUE IN ADDITION TO THE OUSTANDING BALANCE.**
- **IN ADDITION, ALL ACCOUNTS 90 DAYS PAST DUE WILL BE SUBJECT TO INTEREST AT THE RATE OF 2% PER MONTH.**
- **ANY PATIENT WHO FAILS TO SHOW UP FOR THEIR APPOINTMENT, AND DOES NOT CALL TO CANCEL AT LEAST 24 HOURS IN ADVANCE, MAY BE CHARGED $25.00.**
- **PLEASE KNOW THAT WAIVING DEDUCTIBLE AND CO-PAYMENT CHARGES IS ILLEGAL, AND A BREACH OF CONTRACT WITH THE INSURANCE COMPANIES.**

Insurance Coverage

If your insurance company requires a referral from your primary care physician, **it is your responsibility to obtain the referral/referral number from your primary care physician and bring it with you to your visit.** If you do not have a referral/referral number and your insurance company requires it, we may have to reschedule your appointment.

Thank you for your understanding and cooperation. Please let us know if you have any questions or concerns.

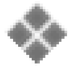
I have read the Financial Policy described above, and understand and agree to all of its provisions.

____

Signature of the Patient or Responsible Party **Date**

____

Print Name of Patient or Responsible Party



Thomas Dermatology

General and Pediatric Dermatology
MOHS Surgery and Cosmetic Dermatology

HIPAA NOTICE of PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

INTRODUCTION

At Thomas Dermatology, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective, and applies to all protected health information as defined by federal regulations.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, ***Stephanie Mendoza*** at 702-430-5333 Ext. 139. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is: *Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.*

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Thomas Dermatology's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____
____
____
____
____

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

Spouse Child Parent Guardian Other: ____________________________________
(please circle correct choices)

Signed ____________________________________ Date ____________________

Relationship____