



# 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](http://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.**

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

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

- Do you smoke?  Yes  No
- Do you drink alcohol?  Yes  No
- Do you use sunscreen?  Yes  No
- Have you had at least 1 blistering sunburn in your lifetime?  Yes  No
- Have you ever utilized a tanning bed?  Yes  No
- Do you work indoors or outdoors?  Indoors  Outdoors  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                  | <input type="radio"/> Yes |
| History of Basal Cell Carcinoma                    | <input type="radio"/> Yes |
| History of Squamous Cell Carcinoma                 | <input type="radio"/> Yes |
| History of Melanoma                                | <input type="radio"/> Yes |
| Atypical nevi/Abnormal Moles                       | <input type="radio"/> Yes |
| Actinic Keratosis/Precancerous Lesions of the Skin | <input type="radio"/> Yes |
| Eczema/Dry Skin Conditions                         | <input type="radio"/> Yes |
| Allergies/Hayfever                                 | <input type="radio"/> Yes |
| Asthma   | <input type="radio"/> Yes |
| Food allergies                                     | <input type="radio"/> Yes |
| Psoriasis  | <input type="radio"/> Yes |
| Keloids/ Thick Scars                               | <input type="radio"/> Yes |
| HIV  | <input type="radio"/> Yes |
| Hepatitis B  | <input type="radio"/> Yes |
| Hepatitis C  | <input type="radio"/> Yes |
| Tuberculosis                                       | <input type="radio"/> Yes |
| Diabetes   | <input type="radio"/> Yes |
| COPD/Chronic Obstructive Pulmonary Disease         | <input type="radio"/> Yes |
| Rheumatoid Arthritis                               | <input type="radio"/> Yes |
| Other Autoimmune disorder                          | <input type="radio"/> Yes |
| Thyroid Disorder                                   | <input type="radio"/> Yes |
| Lupus  | <input type="radio"/> Yes |
| High Blood Pressure                                | <input type="radio"/> Yes |
| High Cholesterol                                   | <input type="radio"/> Yes |
| Heart disease                                      | <input type="radio"/> Yes |



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**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

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

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

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

Mohs Surgery or Skin Cancer Surgery  Yes

Organ Transplant-Please specify  Yes

Hysterectomy  Yes

Artificial Heart Valve  Yes

Pacemaker  Yes

Artificial joints - Please Specify and Note Year \_\_\_\_\_  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

<b>PHARMACY NAME:</b>		PHARMACY STORE PHONE NUMBER:
<b>PHARMACY CROSS STREET:</b>		
<b>LIST OF MEDICATIONS:</b>	<b>REASONS FOR USE:</b>	<b>VITAMINS/HERBS/SUPPLEMENTS:</b>
		<b>Females only:</b>
		Are you pregnant? Y N
		Are you nursing? Y N
		<b>ALLERGIES TO THE FOLLOWING</b>
<b>MEDICATION ALLERGIES:</b>	<b>REACTION:</b>	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
<b>Family History of :</b>		<b>HOW DID YOU HEAR ABOUT US?</b>
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	Y N	Ex: Google, Yahoo, Angies List, Dex, MSN, etc
If yes, what type:		

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 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:** \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_

**SIGNATURE OF PATIENT OR AUTHORIZED PERSON** \_\_\_\_\_ **DATE** \_\_\_\_\_



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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.
- YOUR SCHEDULED APPOINTMENT TIME HAS A 15 MINUTE GRACE PERIOD. BEYOND THAT TIME, YOU MAY BE REQUIRED TO RESCHEDULE.
- 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.**

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**Signature of the Patient or Responsible Party**

**Date**

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**Print Name of Patient or Responsible Party**



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## 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:

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

Spouse Child Parent Guardian Other **Name:** \_\_\_\_\_  
(please circle correct choices)

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship** \_\_\_\_\_

9097 W Post Road, Suite 100, Las Vegas, Nevada 89148  
9080 W Post Road, Suite 100, Las Vegas, Nevada 89148  
866 Seven Hills Drive, Suite 201, Henderson, Nevada 89052  
6170 N Durango Drive, Suite 140, Las Vegas Nevada 89149  
Phone: (702) 430-5333 Fax: (702) 430-5335





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[www.thomasderm.com](http://www.thomasderm.com)

## Medical Records Release

**PLEASE ONLY FILL OUT HIGHLIGHTED AREA**

\_\_\_\_ I, the undersigned, do hereby give permission to my physician's office identified below to furnish Thomas Dermatology with any and all information pertaining to my medical records:

\_\_\_\_ I, the undersigned, do hereby give permission to Thomas Dermatology to furnish my physician's office identified below with any and all information pertaining to my medical records:

Dr. Name/Office: \_\_\_\_\_  
Attention: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Please send:  
\_\_\_\_ LABS/BIOPSIES  
\_\_\_\_ X-RAYS/IMAGES  
\_\_\_\_ CHART NOTES  
\_\_\_\_ ITEMIZED BILLING  
\_\_\_\_ OTHER: \_\_\_\_\_

\_\_\_\_ I, the undersigned, do hereby request a copy of my protected health information from Thomas Dermatology. I understand that according to NRS 629.061, a copy of my medical records will be furnished within 30 days after the date of receipt of this request and that there may be a fee of \$0.60 per page. I also understand that I may be required to pay the fee in full before a copy of my records will be released. I also understand that I must pick up my records in person with proper identification.

Please address medical records or any questions to:

9097 West Post Road Suite 100 Las Vegas, NV 89148	9080 West Post Road Suite 100 Las Vegas, NV 89148	866 Seven Hills Drive Suite 201 Henderson, NV 89052	6170 North Durango Drive Suite 140 Las Vegas, NV 89149
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**Print Patient's Name:** \_\_\_\_\_

Patient SSN: \_\_\_\_\_

**Patient birth date:** \_\_\_\_\_

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**WARNING: THIS FAX/EMAIL/MAIL TRANSMISSION MAY CONTAIN CONFIDENTIAL MEDICAL INFORMATION**

IT IS UNLAWFUL FOR ANY UNAUTHORIZED PERSON TO REVIEW, COPY, DISCLOSE, OR DISSEMINATE CONFIDENTIAL MEDICAL INFORMATION. IF THE READER OF THIS WARNING IS NOT THE INTENDED RECIPIENT OR THEIR AGENT, YOU ARE HEREBY NOTIFIED THAT YOU HAVE RECEIVED THIS TRANSMISSION IN ERROR; PLEASE NOTIFY US IMMEDIATELY AT THE TELEPHONE NUMBER LISTED BELOW. THANK YOU.