PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Patient Name: _____ **DOB:** _____ Age: ____ Sex: M or F
Home Address: _____ Apt #: _____ **Social Security #:** _____
City: _____ State: _____ Zip: _____ Marital Status: _____
Home Phone: ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____
Patients Employer: _____ Occupation: _____
E-Mail Address: _____

Spouse's Name: _____ DOB: _____ Age: ____
Social Security #: _____ Work Phone: ( ) _____ Cell: ( ) _____
Spouse's Employer: _____ Occupation: _____

PARENT / RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Mother's Name: _____
Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Phone #: ( ) _____
Occupation: _____

Father's Name: _____
Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Phone #: ( ) _____
Occupation: _____

INSURANCE INFORMATION (PLEASE BRING CARD TO WINDOW)

Primary Insurance: _____
Claiming Mailing Address: _____
Policy #: _____ Group #: _____
Phone #: ( ) _____
Name of Insured: _____
DOB: _____

Secondary Insurance: _____
Claiming Mailing Address: _____
Policy #: _____ Group #: _____
Phone #: ( ) _____
Name of Insured: _____
DOB: _____

Patient Referred: _____
Nearest Friend / Relative (**NOT** living with you): _____ Phone #: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____

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INSURANCE ASSIGNMENT AND MEDICAL RELEASE:

I, the undersigned, do hereby authorize my insuance carrier(s) to pay directly to Lux 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 set insurance carrier(s), including co-pay and/or deductible amounts. I, the undersigned, do hereby also give my permission to Lux Dermatology LV, to furnish my insurance carrier(s) any and all information pertaining to my medical records.

_____ _____
Signature of Patient or Authorized Representative: Date:

Patient Name: _____ DOB: _____

Preferred Language: _____ Race: _____

Ethnic Group: ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Unknown ☐ I choose not to specify

Pharmacy (Name/Cross street/Phone#): _____

Primary Care Provider: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone marrow transplant
BPH
Breast cancer
Colon cancer
COPD
Coronary artery disease
Depression
Diabetes
Elevated Blood Pressure
End stage renal disease
GERD
Hearing loss
Hepatitis
HIV / AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung cancer
Lymphoma
Prostate cancer
Radiation treatment
Seizures
Stroke

Other: _____

Past Medical History: (please circle all that apply)

Appendix removed
Bladder removed
Breast Biopsy (right, left, bilateral)
Lumpectomy (right, left, bilateral)
Mastectomy (right, left, bilateral)
Colectomy
Colostomy
Gallbladder removed
Coronary artery bypass
Biological valve replacement
Mechanical valve replacement
Heart transplant
Hip replacement (right, left, bilateral)
Knee replacement (right, left, bilateral)
Kidney biopsy
Kidney removed (right, left, bilateral)
Kidney stone removal
Kidney transplant
Liver transplant
Ovaries removed: endometriosis, cancer, cyst)
Pancreas removed
Prostate removed: (cancer, TURP)
Prostate Biopsy
Spleen removed
Testicles removed (right, left, bilateral)
Hysterectomy (fibroids, uterine cancer, cervical cancer)
Tubal Ligation

Other: _____

Skin Disease History: (please circle all that apply)

Acne
Actinic keratosis
Asthma
Basal cell skin cancer
Blistering sunburns
Dry skin
Eczema
Flaking / itchy scalp
Hay fever / allergies
Melanoma
Poison Ivy
Precancerous moles
Psoriasis
Squamous cell skin cancer

Other: _____

Do you wear sunscreen? ☐ YES ☐ NO

If yes, what SPF: _____

Do you tan in a tanning salon? ☐ YES ☐ NO

Do you have a family history of malignant melanoma? ☐ YES ☐ NO

If yes, which relative(s): _____

Medications (please list all current medications):

☐ No medications

Drug Allergies (please list all current medications):

☐ No known drug allergies

Social History:

Smoking status:

- ☐ Every day smoker
- ☐ Some day smoker
- ☐ Former smoker
- ☐ Never

Alcohol use:

- ☐ None
- ☐ < 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 of more drinks per day

Occupation:

Alerts (please circle all that apply):

Allergy to adhesive	Artificial joint replacement	MRSA
Allergy to latex	Blood thinners	Pacemaker
Allergy to lidocaine	Defibrillator	Require antibiotics prior to procedure
Artificial valve replacement	Keloid scarring	Rapid heart beat with epinephrine

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? ☐ YES ☐ NO

ARE YOU CURRENTLY BREAST FEEDING? ☐ YES ☐ NO

Review Of Systems: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Problems with bleeding?		
Problems with healing?		
Problems with scarring?		
Any current rashes?		

LUX DERMATOLOGY

An Affiliate of Artius Dermatology Associates, PC

Cancellation Policy / No Show Policy
For Doctors, Cosmetic & Surgery Appointments

1. Cancellation / No Show Policy for Doctors' Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Cancellation / No Show Policy for Cosmetic Appointments

We recognize the time of our clients and staff is valuable and have implemented this policy for this reason. When you miss an appointment with us, we not only lose your business, but also the potential business of other clients who could have schedule an appointment for the same time.

Any cancellations with less than 24 hours of notice are subject to a fifty dollar ($50) cancellation fee. Patients who miss their appointments without giving any prior notice will be charged the entire amount of their deposit.

3. Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 48 hours in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance company.

4. Schedule Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____ _____ _____

Patient Name | Patient / Guardian Signature | Date

Patient Account # _____

(Office Use Only)

MIPS PATIENT INTAKE FORM

Due to requirements from the U.S. Department of HHS, please answer the following questions.

Name: _____ DOB:_____ Email: _____

Do you have any of the following conditions:

- ☐ Coronary Aretery Disease
- ☐ Chronic Obstructive Pulminary Disease (COPD)
- ☐ Diabetes
- ☐ Heart Failure
- ☐ High Blood Pressure (Hypertension)
    - Most recent blood pressure reading : _____ / _____

Last date you saw your Primary Care Provider: _____

Melanoma:

Have you ever been diagnosed with Melanoma? ☐ YES ☐ NO

If YES, did you ever have a chest X-ray, CT,Ultrasound, MRI, or PET? ☐ YES ☐ NO

Tobacco Use:

Please choose the option that best describes your tobacco use:

☐ Never ☐ Current every day Smoker ☐ Current some day smoker ☐ Former Smoker

For **current tobacco users**, select the option that best describes use:

☐ 1-3 cigarettes per day ☐ Up to 1 pack per day ☐ 1-2 packs per day ☐ 2 or more packs a day

Alcohol Use:

How often do you have an alcoholic beverage?

☐ Never ☐ Less than one drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Vaccinations:

Between October 1st, 2020 and Today, did you receive the following vaccinations?

Flu Vaccine: ☐ YES ☐ NO

Pneumonia: ☐ YES ☐ NO

65 & over

Do you have one of the following?

☐ Power of Attorney (Surrogate Decision Maker) Name/Relationship_____ ☐ Living Will (Advance Care Plan) ☐ None

RELEASE OF PERSONAL RECORDS

1075 Roberta Lane, STE 102
Sparks, NV 89431
www.luxdermatologists.com
Phone: 775-209-7065 Fax: 775-636-7635

I, _____, hereby give my permission to LUX Dermatology to release any information pertaining to me to:

1)_____

2)_____

3)_____

(Name of spouse, family, friend or legal guardian)

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____

Patients printed name: _____

Date of Birth: _____

Signed this _____ day of _____, 20____

Patient Signature: _____