Southern Nevada Occupational Health Center

4060 N. MARTIN LUTHER KING BLVD., Ste 101
N. LAS VEGAS, NV 89032
PHONE: (702) 380-1712
FAX: (877) 361-1165

REGISTRATION SHEET

NAME: _____ DATE OF BIRTH: _____

SS#: _____-_____-_____ GENDER: M / F MARITAL STATUS: _____

RACE:_____ CELL: _____ Phone: _____

DRIVERS LICENSE: _____

EMAIL ADDRESS: _____

ADDRESS: _____ APT#: _____

CITY/STATE: _____ ZIP: _____

NAME OF EMPLOYER: _____ WORK PHONE: _____

Thankyou.

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex ☐ M ☐ F	Claim Number (Insurer's Use Only) TBD
Home Address			Age / Height	Weight	Social Security Number
City	State	Zip		Telephone	
Mailing Address	City	State	Zip		Primary Language Spoken
INSURER	**THIRD-PARTY ADMINISTRATOR**		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred		
Employer's Name/Company Name					Telephone
Office Mail Address (Number and Street)					
Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease		Supervisor to Whom Injury Reported
Address or Location of Accident (if applicable)					
What were you doing at the time of the accident? (if applicable)					
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)					
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					Witnesses to the Accident (if applicable)
Nature of Injury or Occupational Disease		Part(s) of Body Injured or Affected			

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERAN ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHROIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date Place Southern Nevada Occupational Health Center Employee's Original or * Electronic Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place	Name of Facility
4060 N Martin Luther King Blvd Ste 101A	Southern Nevada Occupational Health Center

Date / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)
Treatment:		Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from _____ to _____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty If modified duty, specify any limitations/restrictions: _____
X-Ray Findings: *		
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No		
Is additional medical care by a physician indicated? ☐ Yes ☐ No		

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date	Print Health Care Provider's Name	I certify that the employer's copy of this form was delivered to the employer on:
	Amir Nicknam	

Address					INSURER'S USE ONLY
4060 N Martin Luther King Blvd Ste 101A					
City	State	Zip	Provider's Tax I.D. Number	Telephone	
N Las Vegas	NV	89032	26-3434846	702-380-1712	
Health Care Provider's Original or Electronic Signature				Degree (MD, DO, DC, PA-C, APRN) MD	

* Complete and attach Release of Information (Form C-4A) when injured employee signs C-4 Form electronically

SOUTHERN NEVADA OCCUPATIONAL HEALTH CENTER
4060 N Martin Luther King Blvd., Ste. 101 A-B
North Las Vegas, NV 89032
(702) 380-1712 OFFICE
(877)361-1165FAX

CONSENT TO TREATMENT AND CONDITIONS OF ADMISSION

GENERAL POLICY: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping conditions.

My primary language is _____

Initial: _____ **PERSONAL VALUABLES:** This facility does not assume responsibility for lost or stolen items. The facility encourages that personal valuables be left at home or given to family or friends for safekeeping.

Initial: _____ **NON-SMOKING POLICY:** In accordance with regulatory agency standards, this facility is a non-smoking facility. I have received smoking cessation information. If I wish assistance on quitting smoking I may contact the Nevada Tobacco Users Helpline at (1-800-784-8669)

CAMERAS AND SURVEILLANCE EQUIPMENT: Patient has been advised the facility uses cameras and other surveillance equipment to monitor patient/employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

EMERGENCY DEPARTMENT only/ PPO PHYSICIAN NOTIFICATION: It is the responsibility of the patients to inform the hospital of the primary care physician. If the hospital is unable to contact or utilize the services of your physician, a non-PPO physician may be assigned to you. This could result in an increase in cost to you, the patient.
My Primary Care Physician is: _____

Initial: _____ **USE OF THE EMERGENCY DEPARTMENT:** I understand that my insurance carrier/ 3rd party payor have the right to review my record for the use of emergency department. I understand that if the reason for my visit is determined by my insurance/ 3rd party payor to be a non-emergency, I will be responsible for the bill. I will be responsible for my triage bill, if after triage I decide to leave the Emergency Department without being evaluated by an ER physician.

HMO/PPO CLAIM REVIEW: If the patient is a member of a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), the insurance plan may not cover the physicians' or hospital's services or the benefits may be reduced if the physicians or hospital are not participating providers with insurance organizations. Many HMO/PPO Health Plans review emergency visit claims retrospectively. The health plans review board will determine whether the situation was an emergency. This could occur even if the undersigned's physician directed facility and physician charges. The facility is not responsible for determining whether the patient has used a participating provider for their insurance plan.

Initial: _____ I have received information on my Rights and Responsibilities as a patient and on the grievance process.

X_____ Unable to sign: ☐ Serious Condition
Signature of Patient/ Representative / Legal Guardian ☐ _____

Date: _____ Witness: _____ Hospital Representative: _____ Date: _____

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Patient Name _____

FINANCIAL POLICY

Southern Nevada Occupational Health Canter(SNOHC) appreciates the opportunity to participate in your medical care. The services you may receive from Dr. Amir Nicknam have been chosen to correctly diagnose and maintain your health condition. We recognize the need for an understanding between patient and physician regarding financial agreements for your medical care

PLEASE READ AND INITIAL ALL STATEMENTS BELOW

_____ **If you are a Workers Compensation patient, we need a copy of your insurance card in the event your Workers Compensation claim is denied for any reason**

_____ SNOHC will submit a claim to your insurance/Workers Compensation carrier. Upon receipt of payment, SNOHC will then bill your secondary and/or tertiary insurance (if applicable) for any remaining balance based on the explanation of benefits received from your primary and/or secondary insurance company.

_____ Your insurance/Workers Compensation carrier(s) **may not cover** all the services determined by Dr. Nicknam as medically necessary. Please refer to your insurance policy for further clarification and verification of coverage and benefits. Fees for non-covered services are the responsibility of the patient or guarantor.

_____ SNOHC will attempt to appeal what your insurance/Workers Compensation carrier does not pay. In the event of a denied appeal and once all measures in an attempt to overturn an appeal are denied, **I must then submit an appeal to the decision with my insurance or Workers Compensation carrier**

_____ If your insurance company/Workers Compensation carrier **does not pay within 60 days, we reserve the right to begin billing you directly** and recommend that you contact your insurance/Workers Compensation carrier(s) to follow up on the payment status. **Any accounts left unpaid will be placed with a private collection agency.** Any and all accounts will be subject to the costs associated with the collection process.

_____ **I agree that I am responsible for all charges incurred in this office. You as the insured are responsible to pay for any outstanding coinsurance or deductible amounts determined by your insurance carrier or Workers Compensation carrier. If my insurance carrier does not provide full benefits, I agree to pay the remaining balance.**

_____ If any part of your insurance carrier(s) changes, **it is your responsibility to notify SNOHC** so that we can bill your claims properly. **You must provide us with a copy of the new insurance card immediately.** Failure to inform us of any new changes may affect obtaining pre-authorization prior to future appointments and obtaining a future appointment itself with our office.

_____ If your address or telephone number should change at any time, **you must notify the SNOHC billing department** of such changes. Please contact the billing department at 702-733-6622.

_____ **Returned checks and no shows will be subject to a $25.00 fee.**

I authorize the release of any information necessary, including medical history, physical findings and treatment rendered as allowed by HIPAA to determine liability for payment and to obtain reimbursement on my medical claims. I request that payment of authorized payments be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurances and other health plans to SNFM. The assignment of benefits will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original. I understand that I am fully responsible for all charges whether paid by my insurance carrier(s). I have read, understood and agree to the above financial policy.

_____	_____	_____/_____/_____
PRINT PATIENT'S NAME	PATIENT SIGNATURE	TODAYS DATE

4060 N. Martin Luther King Blvd., Ste. 101 A-B, N. Las Vegas, NV 89032 phone (702)380-1712 fax (877)361-1165

Southern Nevada Family Medicine
Southern Nevada Occupation Health Center

Board Certified in Family Medicine

Amir Nicknam, MD., MPH

Chief Medical Officer

Patient Name: _____ Date of Birth: ____/____/____

Pharmacy name: _____ Location: (cross streets, phone number) _____

Reason for today's visit? _____

Please list any hospitalizations and/or operations you have had in the past with approximate dates:

1 _____ 2 _____

3 _____ 4 _____

Please list any medications you take daily, including over the counter medicines:

	MEDICATION	DOSAGE	HOW OFTEN
1			
2			
3			
4			
5			

*** If you take additional medications, please list them on the back of this paper ****

Are you allergic to any medications? Yes No If yes, please list all allergies and reactions below:

_____

FAMILY HEALTH HISTORY

Relative	Current Age	Health Status	Deceased	Age at death	Cause of Death
			Yes No		
			Yes No		
			Yes No		
			Yes No		
			Yes No		

SOCIAL HISTORY

**Do you currently smoke? Y N How many packs per day do you smoke? ____ How many years have you smoked for? ____

If no, have you smoked in the past? Y N What year did you quit? _____ How many packs per day did you smoke? _____

**Do you drink? Y N Daily Weekly Monthly How many drinks? _____

**Do you do recreational drugs? Y N What drugs do you use? _____

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REVIEW OF SYSTEMS: PLEASE INDICATE ANY PERSONAL HISTORY BELOW

SYMPTOMS/SINTOMAS		
Good general health/ Buena salud general	YES	NO
Recent weight change/ Cambio de peso reciente	YES	NO
Fever/Fiebre	YES	NO
Fatigue/Fatiga	YES	NO
Headache/ Dolor de cabeza	YES	NO
EYES/OJOS		
Eye disease or injury/ Enfermedades de los ojos o lesiones	YES	NO
Wear glasses/contact lenses / Use lentes o lentes de contacto	YES	NO
Blurred or double vision/ Visión borrosa o doble	YES	NO
Glaucoma	YES	NO
EAR/NOSE/MOUTH/THROAT OIDO/NARIZ/BOC/GARGANTA		
Hearing loss or ringing/ La perdida de audicion o zumbido	YES	NO
Earache or drainage/ Dolor de oido o drenaje	YES	NO
Chronic sinusitis problems or rhinitis/ problemas cronicos de sinusitis o rinitis	YES	NO
Nosebleeds/ hemorragia nasal	YES	NO
Mouth sores/ llagas en la boca	YES	NO
Bleeding gums/ sangrado de las encias	YES	NO
Bad breath or bad taste/ mal aliento o mal sabor	YES	NO
CARDIOVASCULAR		
Heart trouble/ problemas del corazón	YES	NO
Chest pain or angina pectoris/Dolor de pecho	YES	NO
Palpitations/ palpitaciones	YES	NO
Shortness of breath walking or lying flat/ Falta de aliento cuando camina o se acuesta	YES	NO
Swelling of feet, ankle, or hand/hinchado de los pies, el tobillo o la mano	YES	NO
RESPIRATORY/RESPIRATORIO		
Chronic or frequent cough/ Crónica o frecuentetos	YES	NO
Spitting up blood/tosiendo sangre	YES	NO
Shortness of breath/ falta de aliento	YES	NO
Asthma or wheezing/ asma o sibilancias	YES	NO
GASTROINTESTINAL		
Loss of appetite/ perdida de apetito	YES	NO
Change in bowel movement/ Cambio en el movimiento intestinal	YES	NO
Nausea or vomiting/ Náuseas o vómitos	YES	NO
Painful bowel movement/ movimiento de intestinal doloroso	YES	NO
Constipation/ estreñimiento	YES	NO
Rectal bleeding or blood in stool/ Sangrado rectal o sangre en las heces	YES	NO
Abdominal pain/ dolor abdominal	YES	NO
Peptic ulcer/ ulcera peptica	YES	NO
Stomach or duodenal/ De estomago o duodenal	YES	NO
GENTOURINARY		
Frequent urination/ frecuencia de orinar	YES	NO
Burning or painful urination/ Dolor o ardor al orinar	YES	NO
Blood in urine/ sangre en la orina	YES	NO
Change in force of stream when urinating/ Cambio de fuerza al orinar	YES	NO
Incontinence or dribbling/ La incontinencia o goteo	YES	NO

MUSCULOSKELETAL/ MUSCULOESQUELÉTICO		
Joint pain/ dolor en las articulaciones	YES	NO
Joint stiffness or swellin/ Rigidez en las articulaciones o hinchazón	YES	NO
Weakness of muscle or joints/ Debilidad de los músculos o las articulaciones	YES	NO
Muscle pain or cramps/ Dolor o calambres musculares	YES	NO
Back pain/Dolor espalda	YES	NO
Cold extremities/ extremidades frías	YES	NO
Difficulty Walking/ Dificultad para caminar	YES	NO
INTEGUMENTARY (skin, breast)/TEGUMENTARIO(piel,pecho)		
Rash or itching/ erupción cutánea o picazón	YES	NO
Change in skin color/ cambio en el color de piel	YES	NO
Change in hair or nail/cambio en cabello o unas	YES	NO
Varicose veins/ venas inflamadas	YES	NO
Breast pain/Dolor de pecho	YES	NO
Breast lump/ bultos en los pecho	YES	NO
Breast discharge/ descarga en el pecho	YES	NO
NEUROLOGICAL		
Frequent or recurring headaches/ Dolores de cabeza frecuentes o recurrentes	YES	NO
Lightheadedness or dizzy/ Mareo	YES	NO
Convulsions or seizure/ Convulsiones	YES	NO
Numbness tingling sensation/ Entumecimiento sensación	YES	NO
Tremors/ temblores	YES	NO
Paralysis/ parálisis	YES	NO
Stroke/ Apoplejía	YES	NO
Head injury/ lesión en la cabeza	YES	NO
PSYCHIATRIC/ PSIQUIÁTRICO		
Memory loss or confusion/ Pérdida de la memoria o confusión	YES	NO
Nervousness/ nerviosismo	YES	NO
Depression/ depresión	YES	NO
Insomnia/ insomnio	YES	NO
ENDOCRINE		
Glandular or hormone problems/ Problemas glandulares o de la hormonales	YES	NO
Thyroid disease/ enfermedad de la tiroides	YES	NO
Diabetes (insulin & non-insulin)/ diabetes (insulina y diabetes no insulin-)	YES	NO
Excessive thirst or urination/ excesiva orinacion o sed	YES	NO
Heat or cold interference/ interferencia en calor o frio	YES	NO
Skin becoming dryer/Piel reseca	YES	NO
Change in hat, glove size/ Cambio de tamano en cachucha, o guantes	YES	NO
HEMATOLOGIC/LYMPHATIC HEMATOLÓGICA / LINFATICA		
Slow to heal cuts/despacio en sanar heridas	YES	NO
Bleeding or bruising tendency/tendencia de sangrado o moretones	YES	NO
Anemia	YES	NO
Phlebitis/ flebitis	YES	NO
Enlarged glands/ Inflamación de los ganglios	YES	NO
ALLERGIC/IMMUNOLOGIC ALÉRGICA / INMUNOLÓGICO		
History of skin reaction or other adverse reaction to/ Historia de la reacción de la piel u otra reacción adversa a::		

Patient Name (print): _____ **Date:** _____

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Kidney stones/ cálculo renal	YES	NO	Penicillin or other antibiotics/penicilina o otros antibióticos	YES	NO
Sexual difficulty/ dificultades sexuale	YES	NO	Morphine, Demerol or other narcotics/morfina, Demerol o otros narcoticos	YES	NO
Male- testicular pain/ Hombre-dolor testicular	YES	NO	Novocain or other anesthetics/Novocaina o de otros anestésicos	YES	NO
Female- pain with period/ Mujer-el dolor con período	YES	NO	Aspirin or other pain medicines/Aspirinao otros medicamentos para el dolor	YES	NO
Female- irregular periods/ Mujer-periodos irregulares	YES	NO	Tetanus antitoxin or other serums/Antitoxina tetánica o de otros sueros	YES	NO
No Change from prior visit/ No cambios desde su visita anterior	**YES**	**NO**	**Comments/Commentos:**		

FOR OFFICE USE ONLY:

INJURY:			
Height:	Weight:		
Blood Pressure:	Pulse:	Respiration:	SPO2:
Pain Scale: (1/10) 10 = Highest pain	Allergies:		
Medications Taking:			
Questions, Comments, Concerns:			

Patient Name (print): _____ **Date:** _____