

Southern Nevada Occupational Health Center



**PAGINA DE REGISTRATION**

NOMBRE: \_\_\_\_\_ FECHA DE NACIMIENTO: \_\_\_\_\_

DIRECTION: \_\_\_\_\_ CIUDAD/ESTADO: \_\_\_\_\_

CODIGO POSTAL \_\_\_\_\_ TELEPHONO: \_\_\_\_\_

CELLULAR: \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ GENERO: MALE/FEMALE

ESTADO CIVIL: S/W/M/D RAZA: \_\_\_\_\_ NUMERO DE LICENCIA: \_\_\_\_\_

NOMBRE DE TRABAJO: \_\_\_\_\_ TITULO DEL TRABAJO: \_\_\_\_\_

CORREO ELECTRONICO: \_\_\_\_\_

GRACIAS

Solo para traducción. / For translation only.  
 No rellenes la página / Do not fill page out.

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 NOMBRE	M.I.	Last Name APELLIDO	Birthdate FECHA NACIMIENTO	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only) TBD	
Home Address DIRECCION			Age EDAD	Height ALTURA	Weight PESO	Social Security Number # SEGURO SOCIAL
City CIUDAD	State ESTADO		Zip CODIGO POSTAL		Telephone TELEFONO	
Mailing Address City			State		Zip	
INSURER			THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred OCUPACION DE TRABAJO	
Employer's Name/Company Name NOMBRE DE COMPANIA					Telephone TELEFONO DE COMPANIA	
Office Mail Address (Number and Street) DIRECCION DE COMPANIA						
Date of Injury (if applicable) FECHA DE LESION	Hours Injury (if applicable) HORA DE LESION am pm	Date Employer Notified FECHA QUE NOTIFICO EMPLEADOR	Last Day of Work After Injury or Occupational Disease ULTIMO DIA DE TRABAJO		Supervisor to Whom Injury Reported NOMBRE DE SUPERVISOR	
Address or Location of Accident (if applicable) DIRECCION DONDE PASO ACCIDENTE						
What were you doing at the time of the accident? (if applicable) QUE ESTABA HACIENDO EN EL MOMENTO DEL ACCIDENTE						
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary) COMO OCURRIO ESTA LESION						
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment? CREE QUE TIENE UNA ENFERMEDAD PROFESIONAL?					Witnesses to the Accident (if applicable) NOMBRE DE TESTIGOS	
Nature of Injury or Occupational Disease NATURALEZA DE LA LESION O ENFERMEDAD			Part(s) of Body Injured or Affected PARTE DEL CUERPO LESIONADO			
<small>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 518A TO 518D, 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 AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</small>						
Date FECHA	Place Southern Nevada Occupational Health Center		Employee's Original or Electronic Signature FIRMA			
<b>THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT</b>						
Place 4060 N Martin Luther King Blvd Ste 101A			Name of Facility Southern Nevada Occupational Health Center			
Date	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? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)			
Hour						
Treatment:		Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)						
Date	Print Health Care Provider's Name Amir Nicknam		I certify that the employer's copy of this form was delivered to the employer on:			
Address 4060 N Martin Luther King Blvd Ste 101A			INSURER'S USE ONLY			
City N Las Vegas	State NV	Zip 89032	Provider's Tax I.D. Number 26-3434846	Telephone 702-380-1712		
Health Care Provider's Original or Electronic Signature			Degree (MD, DO, DC, PA-C, APRN) MD			

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FORM C-4  
PLEASE TYPE OR PRINT**

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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)						
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Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected			
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	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		

**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

Consentimiento al tratamiento y condiciones de admision

Política general: todos los pacientes serán tratados, admitidos y asignados alojamiento sin distinción a raza, religión, color, origen nacional, edad o condiciones discapacidad.

Mi idioma principal es \_\_\_\_\_

Inicial: \_\_\_ objetos de valor personales: esta instalación no asume responsabilidad por objetos perdidos o robados. La instalación fomenta que los objetos de valor personales sean dejados en casa o dados a la familia o amigos para su custodia.

Inicial: \_\_\_ política para no fumadores: de acuerdo con las normas de los organismos reguladores, esta instalación es una instalación para no fumadores. He recibido información sobre el cese de fumar. Si deseo asistencia para dejar de fumar, puedo contactar con la línea de ayuda de los consumidores de tabaco de Nevada al (1-800-784-8669)

Cámaras y equipo de vigilancia: se ha advertido al paciente que la instalación utiliza cámaras y otros equipos de vigilancia para monitorear las actividades del paciente/empleada. Como condición de admisión, el paciente consiente por este medio ser monitoreado y registrado por tales cámaras y equipos de vigilancia.

Notificación del médico del Departamento de emergencias solamente/PPO: es responsabilidad de los pacientes informar al hospital del médico de atención primaria. Si el hospital no puede contactar o utilizar los servicios de su médico, un médico que no es de PPO puede ser asignado a usted. Esto podría resultar en un aumento en el costo para usted, el paciente.

mi médico de atención primaria es: \_\_\_\_\_

Inicial: uso del Departamento de emergencias: entiendo que mi compañía de seguros/tercero pagador tiene el derecho de revisar mi expediente para el uso del Departamento de emergencias. Entiendo que si la razón de mi visita es determinada por mi seguro/tercero pagador para ser una no-emergencia, seré responsable de la cuenta. Yo seré responsable de mi proyecto de ley Triage, si después de la Triage decido dejar el Departamento de emergencias sin ser evaluado por un médico de urgencias.

Revisión de la reclamación de HMO/PPO: Si el paciente es miembro de una organización de mantenimiento de la salud (HMO) o una organización de proveedores preferidos (PPO), el plan de seguro no puede cubrir los servicios de los médicos o del hospital o los beneficios pueden reducirse si los médicos o Hospital no son proveedores participantes con organizaciones de seguros. Muchos planes de Salud HMO/PPO revisan las solicitudes de visita de emergencia retrospectivamente. La Junta de revisión de planes de salud determinará si la situación fue una emergencia.

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

.X \_\_\_\_\_

Date: \_\_\_\_\_

Firma del paciente

**Southern Nevada Family Medicine**  
**Southern Nevada Occupation Health Center**  
 Board Certified in Family Medicine

Amir Nicknam, MD., MPH  
 Chief Medical Officer



Nombre de paciente: \_\_\_\_\_ Fecha de nacimiento: \_\_\_/\_\_\_/\_\_\_

Nombre de farmacia: \_\_\_\_\_ Locacion: (calles de interseccion, # de telefono) \_\_\_\_\_

Razon para su visita de hoy? \_\_\_\_\_

Por favor anote cualquier hospitalizacion y/o cirujias que a tenido en el pasado con fechas aproximadas:

1 \_\_\_\_\_ 2 \_\_\_\_\_

3 \_\_\_\_\_ 4 \_\_\_\_\_

Lista de medicinas que toma diaramente, incluyendo medicinas no recetadas:

MEDICINA	DOSIS	CADA CUANTO
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

\*\*\*Si toma medicina adicional, por favor anote atras de este \*\*\*\*

Es alergica a una medicina? Si No Si? Mencione las alergias/reacciones abajo:

HISTORIAL FAMILIAR

<u>Pariente</u>	<u>Edad</u>	<u>Estado de Salud</u>	<u>Muerto(a)</u> Si No	<u>Edad que fallecio?</u>	<u>Causa de muerte?</u>
_____	_____	_____	Si No	_____	_____
_____	_____	_____	Si No	_____	_____
_____	_____	_____	Si No	_____	_____
_____	_____	_____	Si No	_____	_____
_____	_____	_____	Si No	_____	_____

HISTORIAL SOCIAL

\*\*Fuma? Si No Cuantos paquetes fuma al dia? \_\_\_ Por cuantos años a fumado? \_\_\_

Si no, a fumado en el pasado? Si No En que año dejo de fumar? \_\_\_ Cuantos paquetes fumaba al dia? \_\_\_

\*\*Toma alcohol? Si No Todos los dias Semanalmente Mensualmente Ocasionalmente?

Cuantas bebidas alcoholicas toma? \_\_\_

\*\*Hace drogas? Si No Que drogas usa? \_\_\_\_\_

# Southern Nevada Occupational Health Center



Patient Name \_\_\_\_\_

## FINANCIAL POLICY

Southern Nevada Occupational Health Center(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

Southern Nevada Occupational health Center  
**REVIEW OF SYSTEMS: PLEASE INDICATE ANY PERSONAL HISTORY BELOW**

SYMPTOMS/SINTOMAS			MUSCULOSKELETAL/ MUSCULOESQUELÉTICO		
Good general health/ Buena salud general	YES	NO	Joint pain/ dolor en las articulaciones	YES	NO
Recent weight change/ Cambio de peso reciente	YES	NO	Joint stiffness or swelling/ Rigidez en las articulaciones o hinchazón	YES	NO
Fever/Fiebre	YES	NO	Weakness of muscle or joints/ Debilidad de los músculos o las articulaciones	YES	NO
Fatigue/Fatiga	YES	NO	Muscle pain or cramps/ Dolor o calambres musculares	YES	NO
Headache/ Dolor de cabeza	YES	NO	Back pain/Dolor espalda	YES	NO
			Cold extremities/ extremidades frías	YES	NO
<b>EYES/OJOS</b>			Difficulty Walking/ Dificultad para caminar	YES	NO
Eye disease or injury/ Enfermedades de los ojos o lesiones	YES	NO			
Wear glasses/contact lenses / Use lentes o lentes de contacto	YES	NO	<b>INTEGUMENTARY (skin, breast)/TEGUMENTARIO(piel,pecho)</b>		
Blurred or double vision/ Visión borrosa o doble	YES	NO	Rash or itching/ erupción cutánea o picazón	YES	NO
Glaucoma	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
<b>EAR/NOSE/MOUTH/THROAT OIDO/NARIZ/BOC/GARGANTA</b>			Varicose veins/ venas inflamadas	YES	NO
Hearing loss or ringing/ La perdida de audicion o zumbido	YES	NO	Breast pain/Dolor de pecho	YES	NO
Earache or drainage/ Dolor de oido o drenaje	YES	NO	Breast lump/ bultos en los pecho	YES	NO
Chronic sinusitis problems or rhinitis/ problemas cronicos de sinusitis o rinitis	YES	NO	Breast discharge/ descarga en el pecho	YES	NO
Nosebleeds/ hemorragia nasal	YES	NO			
Mouth sores/ llagas en la boca	YES	NO	<b>NEUROLOGICAL</b>		
Bleeding gums/ sangrado de las encias	YES	NO	Frequent or recurring headaches/ Dolores de cabeza frecuentes o recurrentes	YES	NO
Bad breath or bad taste/ mal aliento o mal sabor	YES	NO	Lightheadedness or dizzy/ Mareo	YES	NO
			Convulsions or seizure/ Convulsiones	YES	NO
<b>CARDIOVASCULAR</b>			Numbness tingling sensation/ Entumecimiento sensación	YES	NO
Heart trouble/ problemas del corazón	YES	NO	Tremors/ temblores	YES	NO
Chest pain or angina pectoris/Dolor de pecho	YES	NO	Paralysis/ parálisis	YES	NO
Palpitations/ palpitaciones	YES	NO	Stroke/ Apoplejía	YES	NO
Shortness of breath walking or lying flat/ Falta de aliento cuando camina o se acuesta	YES	NO	Head injury/ lesión en la cabeza	YES	NO
Swelling of feet, ankle, or hand/hinchado de los pies, el tobillo o la mano	YES	NO			
			<b>PSYCHIATRIC/ PSIQUIÁTRICO</b>		
<b>RESPIRATORY/RESPIRATORIO</b>			Memory loss or confusion/ Pérdida de la memoria o confusión	YES	NO
Chronic or frequent cough/ Crónica o frecuentetos	YES	NO	Nervousness/ nerviosismo	YES	NO
Spitting up blood/tosiendo sangre	YES	NO	Depression/ depresión	YES	NO
Shortness of breath/ falta de aliento	YES	NO	Insomnia/ insomnio	YES	NO
Asthma or wheezing/ asma o sibilancias	YES	NO			
			<b>ENDOCRINE</b>		
<b>GASTROINTESTINAL</b>			Glandular or hormone problems/ Problemas glandulares o de la hormonales	YES	NO
Loss of appetite/ perdida de apetito	YES	NO	Thyroid disease/ enfermedad de la tiroides	YES	NO
Change in bowel movement/ Cambio en el movimiento intestinal	YES	NO	Diabetes (insulin & non-insulin)/ diabetes (insulina y diabetes no insulin-)	YES	NO
Nausea or vomiting/ Náuseas o vómitos	YES	NO	Excessive thirst or urination/ excesiva orinacion o sed	YES	NO
Painful bowel movement/ movimiento de intestinal doloroso	YES	NO	Heat or cold interference/ interferencia en calor o frio	YES	NO
Constipation/ estreñimiento	YES	NO	Skin becoming dryer/Piel reseca	YES	NO
Rectal bleeding or blood in stool/ Sangrado rectal o sangre en las heces	YES	NO	Change in hat, glove size/ Cambio de tamaño en cachucha, o guantes	YES	NO
Abdominal pain/ dolor abdominal	YES	NO			
Peptic ulcer/ ulcera peptica	YES	NO	<b>HEMATOLOGIC/LYMPHATIC HEMATOLÓGICA / LINFÁTICA</b>		
Stomach or duodenal/ De estomago o duodenal	YES	NO	Slow to heal cuts/despacio en sanar heridas	YES	NO
			Bleeding or bruising tendency/tendencia de sangrado o moretones	YES	NO
<b>GENTOURINARY</b>			Anemia	YES	NO
Frequent urination/ frecuencia de orinar	YES	NO	Phlebitis/ flebitis	YES	NO
Burning or painful urination/ Dolor o ardor al orinar	YES	NO	Enlarged glands/ Inflamación de los ganglios	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	<b>ALLERGIC/IMMUNOLOGIC ALÉRGICA / INMUNOLÓGICO</b>		
Incontinence or dribbling/ La incontinencia o goteo	YES	NO	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:** \_\_\_\_\_

Southern Nevada Occupational health Center

Kidney stones/ cálculo renal	YES	NO	Penicillin or other antibiotics/penicilina o otros antibióticos	YES	NO
Sexual difficulty/ dificultades sexuales	YES	NO	Morphine, Demerol or other narcotics/morfina, Demerol o otros narcóticos	YES	NO
Male- testicular pain/ Hombre-dolor testicular	YES	NO	Novocain or other anesthetics/Novocaína o de otros anestésicos	YES	NO
Female- pain with period/ Mujer-el dolor con período	YES	NO	Aspirin or other pain medicines/Aspirina o 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
<b><u>No Change from prior visit/ No cambios desde su visita anterior</u></b>	YES	NO	<b>Comments/Comentarios:</b>		

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