**Ernest M. Sussman, MD**
**9280 W. Sunset Rd., Ste. 400, Las Vegas, NV 89148**
**Ph: (702) 293-0176; Fax: (979) 705-9586**

**PATIENT INFORMATION: PLEASE PRINT** **DATE:** _____

Name: _____Date of Birth: _____Age: _____Marital Status: ____

Address: _____City: _____State: _____Zip Code: _____

Phone: _____ Email:_____

Employer: _____Work Phone: _____ Social Security #:_____

Emergency Contact: _____Relation: _____Phone:_____

MEDICATIONS:_____

ALLERGIES: _____ BLEEDING DISORDERS: _____

OPERATIONS:_____

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**:

I hereby authorize medical treatments for myself and fully acknowledge that all office visits including procedures are on a no-insurance (self-pay) basis. Payment in full is expected at the time of service, unless other arrangements have been made prior. **I further understand that Dr. Sussman does not participate in Medicare, Medicaid, or other commercial insurance companies so am responsible for all fees incurred.**

**Please initial at each 'X' below and sign:**

**X**_____ I understand that any deposit(s) made to hold my procedure appointment are non-refundable, unless the office is given notice (by phone) at least 10 business days prior. In the event of default on any payment due to **Dr. Sussman**, I agree to pay the costs of collection and/or attorney fees.

**X** _____I hereby authorize the office of **Dr. Sussman** to release all pertinent medical records necessary to facilitate insurance billing or medical care. I also authorize the creditor or higher agent to make any employment, or insurance verification and release all information to process claims.

Signature: _____ Date: _____

| **PAST MEDICAL, FAMILY, SOCIAL HISTORY** (CHECK AND *CIRCLE WHICH APPLY*) | **YOU** | **FAMILY** |
|---|---|---|
| High blood pressure, heart attack, heart failure, irregular heart rhythm | ____ | _____ |
| Breathing problems (asthma, COPD, emphysema, chronic bronchitis) | ____ | [redacted] |
| Blood thinners (aspirin, coumadin, Eliquis, ibuprofen, Plavix, Xarelto) | ____ | [redacted] |
| Prosthetic or implant surgery (heart valves, pacemaker, orthopedic, penile) | ____ | [redacted] |
| History of diabetes, tuberculosis or hepatitis | ____ | _____ |
| Cancer of prostate, bladder, kidney, or other_____ | ____ | _____ |
| Risk for HIV (homosexual, blood transfusions, hemophilia) | ____ | [redacted] |
| Do you or have you ever smoked? If you quit, when? _____ | ____ | [redacted] |
| Alcohol or drug _____ use (social, moderate, heavy) | ____ | _____ |