Desert West Surgery

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1111 Shadow Lane Las Vegas, NV 89102
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9260 Sunset Road Suite 206, Las Vegas, NV 89148

New Patient Information Packet

PLEASE ARRIVE 20 MINUTES EARLY FOR YOUR APPT

Date: _____/_____/_____

Dear _____,

Welcome to Desert West Surgery. We would like to have you take a few moments and complete the enclosed information packet. Please bring the entire packet completely filled out along with your **insurance cards, referral forms from your primary care provider (if required) and your office co-payment to your appointment. (PHOTO I.D. IS REQUIRED)**

If you have any of the following tests done in the last six months, please bring the results with you or have your referring physician fax them to our office at 702-383-0526:

- **LAB TESTS/PATHOLOGY REPORTS/EKG**
- **XRAYS/ ULTRASOUNDS/ CAT SCANS, I.E. BARIUM ENEMA OR UPPER GI**
- **MAMMOGRAM/ BREAST ULTRASOUNDS REPORTS AND/OR FILMS**
- **COLONOSCOPY REPORTS WITH PATHOLOGY**

It is very important that you bring this information with you or make arrangements to have it here prior to your appointment so your appointment will not be delayed or possibly rescheduled.

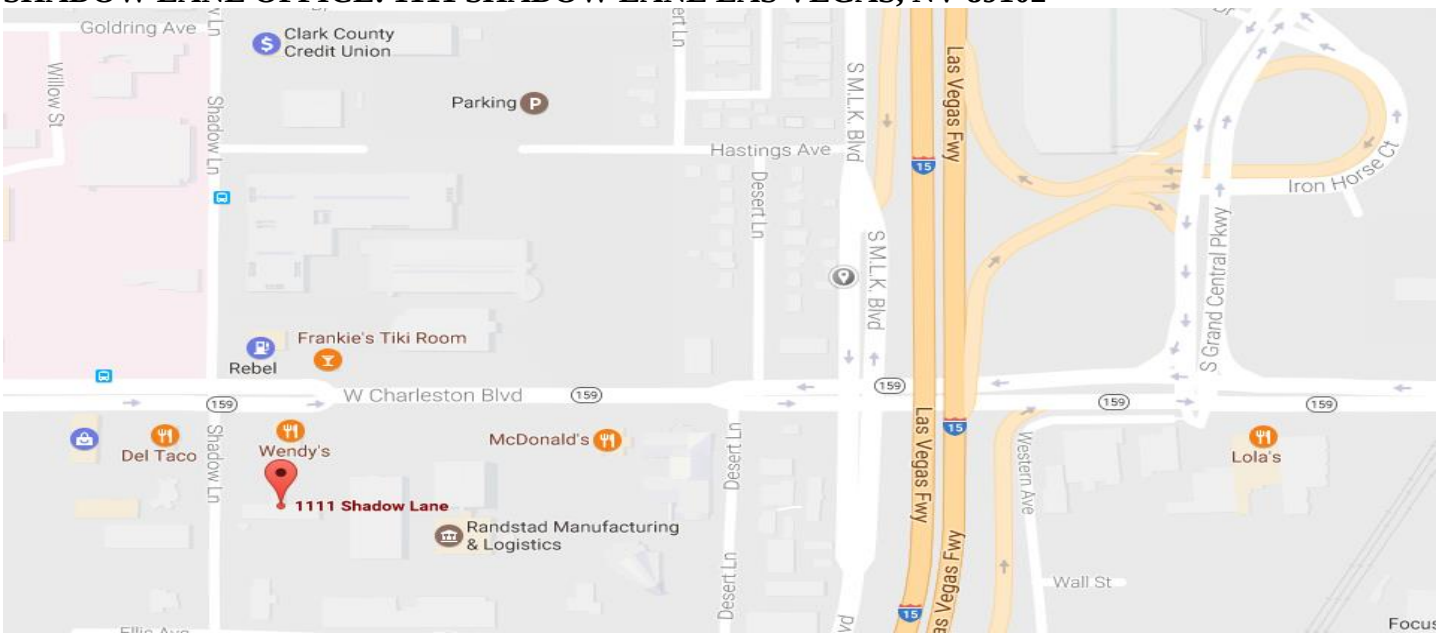
YOUR APPOINTMENT IS SCHEDULED:
DATE: _____/_____/_____ □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday
TIME: _____ □ AM □ PM
LOCATION:

- **□ 1111 SHADOW LANE, LAS VEGAS, NV 89102**
- **□ 7200 CATHEDRAL ROCK DR. STE. 250, LAS VEGAS, NV 89128**
- **□ 9260 SUNSET ROAD SUITE 206, LAS VEGAS, NV 89148**

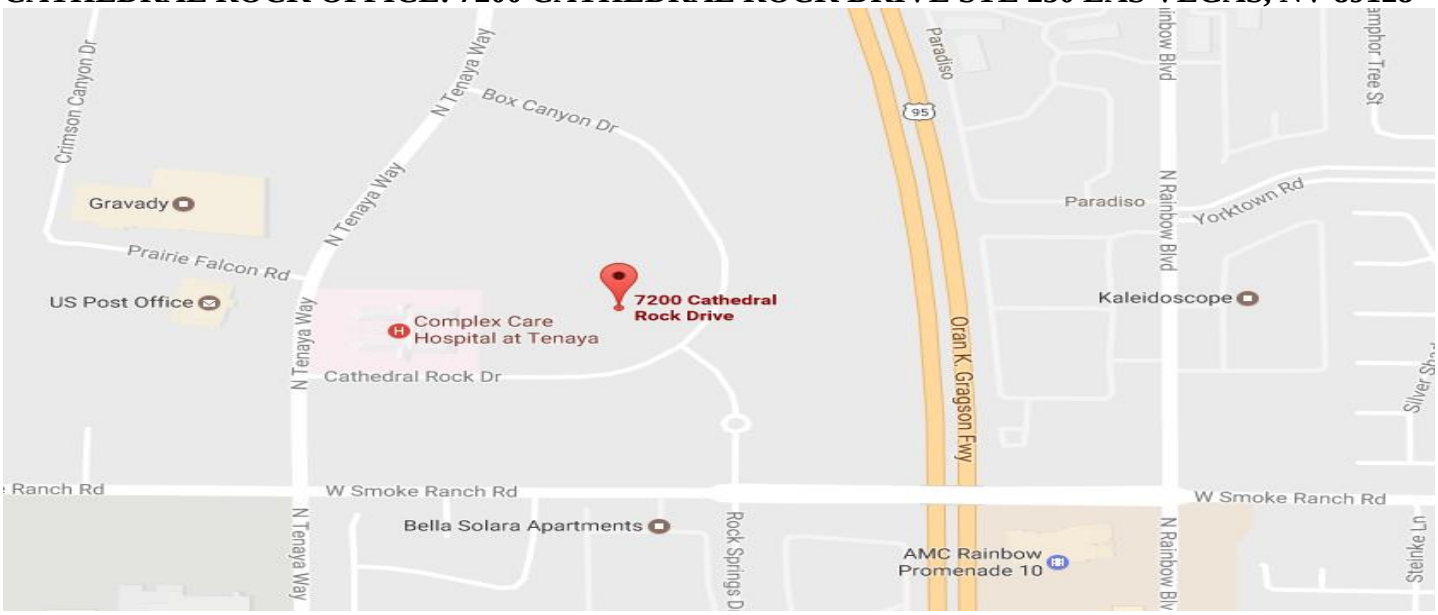
Please call 24 hours before you scheduled appointment if you are canceling or need to reschedule.

Thank you!

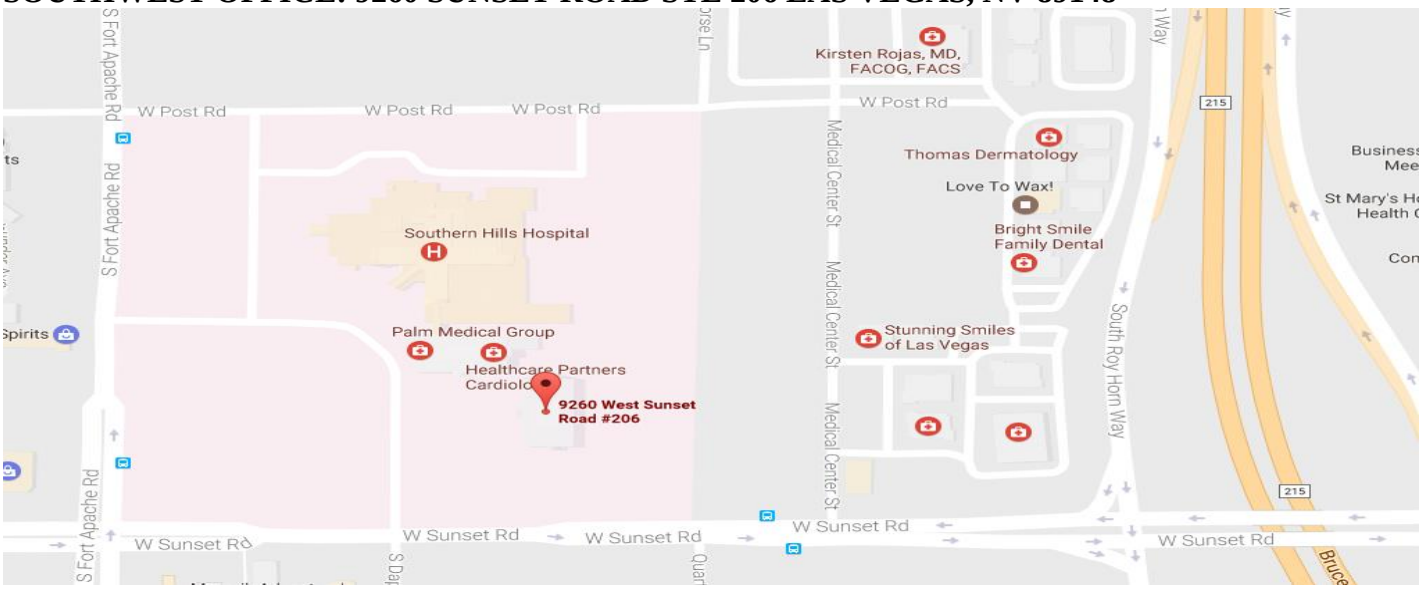
SHADOW LANE OFFICE: 1111 SHADOW LANE LAS VEGAS, NV 89102



CATHEDRAL ROCK OFFICE: 7200 CATHEDRAL ROCK DRIVE STE 250 LAS VEGAS, NV 89128



SOUTHWEST OFFICE: 9260 SUNSET ROAD STE 206 LAS VEGAS, NV 89148



Desert West Surgery

Patient Information

Last Name: _____ First Name: _____ MI: _____
Gender: □ Male □ Female SSN: _____-_____-_____ Date of Birth: _____/_____/_____
MM DD YY

Marital Status: □ Divorced □ Married □ Separated □ Single □ Widowed
Race: □ American Indian/Alaskan Native □ Asian □ Black or African American
□ Native Hawaiian/Other Pacific Islander □ White □ Other Race
Interpreter services needed? _____
Any specific cultural or religious preferences? _____
How do you prefer to be addressed in a greeting/salutation? _____
Ethnic Group: _____ Language: _____
Address: _____ Apt_____
City: _____ State: _____ Zip: _____
Phone Number: _____ □ Home □ Cellular □ Work
2nd Phone Number: _____ □ Home □ Cellular □ Work
E-mail address: _____
Preferred Contact: □ Phone □ Mail □ E-mail
Preferred Reminder: □ Home Phone □ Cell Phone □ Work Phone
May a voice message be left as a reminder for you? □ Yes □ No
Student Status (if applicable): □ Full-Time Student □ Part-Time Student
Employment Status: □ Employed Full-Time □ Employed Part-Time □ Not Employed
□ Self-Employed □ Disabled □ Retired
□ On Active Military Duty
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Employer Phone: _____ Employer Fax: _____
Referring Dr.: _____ Phone: _____ Fax: _____
Referring Dr. Address: _____ City: _____ State: ____ Zip: _____

Insurance Coverage Information

Primary Insurance Name: _____
Address to send claims: _____ City: _____ State: _____ Zip: _____
Policy Number: _____ Group Number: _____
Policyholders Name: _____ Relationship to Patient: _____
Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____
Policyholders Phone Number: _____ □ Home □ Cellular □ Work
Employers Name: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Employer Phone: _____ Employer Fax: _____

Secondary Insurance Name: _____
Address to send claims: _____ City: _____ State: _____ Zip: _____
Policy Number: _____ Group Number: _____
Policy Holders Name: _____ Relationship to Patient: _____
Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____
Policyholders Phone Number: _____ □ Home □ Cellular □ Work
Employers Name: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Employer Phone: _____ Employer Fax: _____

Patient Name: _____ DOB: ____/____/____

For office use:

Patient's Medical History

Reason for Visit: _____

Past Medical History: Check yes or no

Heart Attack (MI): □Yes □ No Thyroid Problems: □ Yes □ No
Heart Failure (CHF): □ Yes □ No Seizures: □ Yes □ No
Atrial Fibrillation: □ Yes □ No Kidney Disease: □ Yes □ No
High Blood Pressure: □ Yes □ No Liver Disease: □ Yes □ No
Diabetes: □ Yes □ No HIV: □ Yes □ No
High Cholesterol: □ Yes □ No Hepatitis: □ Yes □ No
Stroke (TIA): □ Yes □ No Blood Clots: □ Yes □ No
Emphysema: □ Yes □ No Varicose Veins: □ Yes □ No
Anesthesia Problems: □ Yes □ No Bleeding Problems: □ Yes □ No
Other Medical History: _____
_____
_____

Social History: Alcohol: □ Yes □ No Tobacco: □ Yes □ No
Family History: _____
_____

Surgical History: Check All That Apply

□ Heart Surgery □ Thyroid Surgery □ Carotid Artery Surgery □ Hernia - type: _____
□ Colon Surgery □ Gallbladder Surgery □ Hysterectomy □ Colonoscopy/EGD if yes Date(s): _____
Other Surgical History: _____

Medications: Check One □ Yes □ No List Medications: _____
_____
_____

Drug Allergies: Check One □ Yes □ No List Drug Allergies: _____
_____
_____

Check All That Apply

Constitutional: □ Fever □ Chills □ Weight Loss (unintentional) □ Excessive Fatigue
Eyes: □ Double Vision □ Eye Pain □ Glaucoma
ENT: □ Hearing Problems □ Ringing in Ears □ Dentures □ Hoarseness
Cardiac: □ Chest Pain □ Palpitations □ Shortness of Breath
Respiratory: □ Cough □ Coughing-up blood □ Wheezing □ Asthma □ Sleep Apnea □ Shortness of Breath
GI: □ Diarrhea □ Black Stools □ Blood in Stools □ Constipation
GU: □ Burning when urinating □ Blood in Urine □ Frequent Urination □ Prostate Problems □ History of Urinary Tract Infections
Musculoskeletal: □ Calf Pain □ Weakness □ Joint Pain □ Joint Swelling □ Leg Swelling
Neurologic: □ Fainting/Blackouts □ Seizures
Hematological: □ Hepatitis □ Easy Bruising □ Clotting Disorder □ Excessive Bleeding □ Previous Transfusion □ Lymph Node Swelling
Endocrine: □ Heat /Cold Intolerance □ Excessive Sweating
Immunologic/ID: □ Tuberculosis □ Immunosupression □ HIV
Psychiatric: □ Anxiety □ Depression □ Suicidal Thoughts
Breast/Skin: □ Breast Mass □ Breast Skin Changes □ Breast Tenderness □ Nipple Discharge

□ Fungal Nail Infection □ Jaundice
Patient Name: _____ DOB: ____/____/____

Patient's Treating Physicians (Please DO NOT leave blank, write N/A for each doctor that is not applicable.)

Primary Care Dr.: _____ Phone: _____ Fax: _____

Oncologist: _____ Phone: _____ Fax: _____

Gastroenterologist: _____ Phone: _____ Fax: _____

Cardiologist: _____ Phone: _____ Fax: _____

Pulmonologist: _____ Phone: _____ Fax: _____

Gynecologist: _____ Phone: _____ Fax: _____

Urologist: _____ Phone: _____ Fax: _____

Other Specialty: _____ Phone: _____ Fax: _____

Pharmacy Information (Please bring your prescription bottle(s) to your first appointment)

Pharmacy Name: _____
Address or Cross Streets: _____
Phone Number: _____ Fax Number: _____

Confidentiality and Authorization

Please list name(s) and relationships of **ALL** persons authorized to obtain medical and financial information. If no person is to be given this information, please check below:

☐ **"ALL PERSONS DENIED"**

1. Name: _____ Relationship: _____
   Phone Number: _____ □ Home □ Cellular □ Work
   2nd Phone Number: _____ □ Home □ Cellular □ Work

2. Name: _____ Relationship: _____
   Phone Number: _____ □ Home □ Cellular □ Work
   2nd Phone Number: _____ □ Home □ Cellular □ Work

3. Name: _____ Relationship: _____
   Phone Number: _____ □ Home □ Cellular □ Work
   2nd Phone Number: _____ □ Home □ Cellular □ Work

4. Name: _____ Relationship: _____
   Phone Number: _____ □ Home □ Cellular □ Work
   2nd Phone Number: _____ □ Home □ Cellular □ Work

5. Name: _____ Relationship: _____
   Phone Number: _____ □ Home □ Cellular □ Work
   2nd Phone Number: _____ □ Home □ Cellular □ Work

Patient Name: _____ DOB: ____/____/____

If you do not have medical insurance please inform the front desk at this time so that you can make arrangements with the billing department.

Insurance Authorization/Financial Policy

I authorize treatment and I understand that I am financially responsible for all charges and services rendered to my spouse, child or myself. I understand that Desert West Surgery is billing my insurance as a courtesy and that I am ultimately responsible for seeing that my insurance carrier reimburses Desert West Surgery. I authorize payment of medical benefits to the physicians of Desert West Surgery. (A copy of this is as valid as the original)

X_____ Date: _____

Release of Information

The undersigned hereby authorizes and requests the physicians and the staff of Desert West Surgery to provide any medical information necessary to process my medical claims with no limitation placed on dates, history or illness, diagnostic and therapeutic information, including and treatment for alcohol and/or drug abuse. I also give authorization for the physicians of Desert West Surgery to obtain or provide any information from my previous/current physicians or hospitals involved in my care with no limitations placed on dates, history or illness, diagnostic and therapeutic information, including any treatment for alcohol and/or drug abuse.

X_____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

X_____ Date: _____

_____ _____

Relationship to Patient Reason Patient is Unable to Sign

Patient Name: _____ DOB: ____/____/____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Desert West Surgery to use and disclose protected health information **(PHI)** about me to carry out treatment, payment and health care operations **(TPO)**. The Notice of Privacy Practices provided by Desert West Surgery describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Desert West Surgery reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Desert West Surgery

1111 Shadow Lane

Las Vegas, NV 89102

With this consent, Desert West Surgery may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items and call pertaining to my clinical care, including laboratory test results, among others.

With this consent, Desert West Surgery may mail to my house or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements.

With this consent, Desert West Surgery may e-mail to my house or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements. I have the right to request Desert West Surgery restrict how it uses or discloses my **PHI** to carry out **TPO**. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am Consenting to allow Desert West Surgery to use and disclose my **PHI** to carry out **TPO**. I may revoke my consent in writing except to the consent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Desert West Surgery may decline to provide treatment to me.

X_____ Date: _____

_____ _____

Print Patient's Name Print Name of Legal Guardian, if applicable

Notice of Privacy Practices Statement

Notice of Information Practices and Privacy Statement
For Desert West Surgery

How We Collect Information about You: Desert West Surgery and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, e-mails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do/Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via e-mail, on the phone (including information left on voice mails), contained in or attached to applications, or directly on indirectly given to us, is held in the strictest confidence.
We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Desert West Surgery and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications and/or insurance.
If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or unwillful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Desert West Surgery. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.