SOUTHERN NEVADA SURGERY SPECIALISTS

Name ______________________________ Date of Birth____/____/______
(Last) (First) (Middle Initial)

SS# ______________ Email Address ______________________________

Primary Phone ______________ Cell ☐ Home ☐ Secondary Phone ______________ Cell ☐ Home ☐

Would you like to receive appointment and billing text reminders? Yes ☐ No ☐

Address____
(Street) (City) (State) (Zip)

Primary Language ______________ Race ______________ Ethnicity ______________

Employer ______________________________ Work # ______________

Marital Status ______________ Spouse's Name ______________________________

Referring Physician ______________________________ Office # ______________

Primary Care Physician ______________________________ Office # ______________

Pharmacy ______________ Cross Streets ______________ Phone # ______________

Emergency contact and person approved to receive personal medical information:

Name ______________ Phone # ______________ Relationship ______________

Primary Insurance

Insurance Company ______________________________ Phone # ______________

Name of Policy Holder ______________________________ Date of Birth ____/____/______

SS# ______________ Member ID # ______________ Group/Local # ______________

Employer/ Retired from ______________________________ Work Phone # ______________

Co-pay or % due __________ Is this work related? __________ Date of Injury ____/____/______

Secondary Insurance

Insurance Company ______________________________ Phone # ______________

Name of Policy Holder ______________________________ Date of Birth ____/____/______

SS# ______________ Member ID # ______________ Group/Local # ______________

Employer/ Retired from ______________________________ Work Phone # ______________

Financial Responsibility Acknowledgment

As a service, we will submit billing for all services rendered. It is the patient's responsibility to know copayment, deductibles, and which facilities are contracted with your insurance company for any outside testing. For office visits and in office procedures, co-payments and deductibles will be collected before surgery is performed. Delinquent accounts will be turned over to a collection agency. In the event your account is turned over for collections, you will be responsible for all reasonable collection and court costs. Any cash patient discounts that are given by Southern Nevada Surgery Specialists will become void and the full balance must be paid if your account becomes delinquent. Thank you for choosing us as your health care provider. We appreciate your trust in us and look forward to the opportunity to serve you. I have read and understand the above statements.

____
(Patient/ Responsible Party) (Date)

Records Release Authority

I hereby authorize Southern Nevada Surgery Specialists to obtain and send my records from my applicable doctor's office, facility or hospital. These records include but are not limited to pathology reports, diagnostic reports and/or films, operative notes, doctor's notes, etc.

____
(Patient Signature) (Date)

General Health History

Date: ________________________

Name: ____ Date of birth: ___________ Sex: M _____ F _____

Primary care physician: _________________________________ Last check up: ___________ Height: ____________

Do you have an advance directive or living will? Yes _______ No _______

Medical History	Yes	No	Treatment Required
Anemia	_____	_____	____
Arthritis	_____	_____	____
Asthma	_____	_____	____
Blood Clots/PE/DVT	_____	_____	____
Cancer	_____	_____	____
Congestive Heart Failure	_____	_____	____
COPD	_____	_____	____
Diabetes	_____	_____	____
Heart Disease	_____	_____	____
High Blood Pressure	_____	_____	____
High Cholesterol	_____	_____	____
HIV	_____	_____	____
Kidney Disease	_____	_____	____
Liver Disease/Hepatitis	_____	_____	____
Pneumonia	_____	_____	____
Seizures	_____	_____	____
Sleep Apnea	_____	_____	____
Ulcers	_____	_____	____
Other	_____	_____	____

Current Medications **If you do not take any medication write none**	**Dose**
1. ____	_______________
2. ____	_______________
3. ____	_______________
4. ____	_______________
5. ____	_______________
6. ____	_______________

Allergies to Medication **If you do not have any medication allergies write none**	**Reaction**
1. ____	____________________________
2. ____	____________________________
3. ____	____________________________

Name: ____ Date of Birth: _______________________

Past Surgical History	Yes	No	Date	Past Surgical History	Yes	No	Date
Appendectomy	____	____	_________	Lower Extremity Bypass	____	____	_________
Gallbladder	____	____	_________	Prostate	____	____	_________
Inguinal (Groin) Hernia	____	____	_________	Joint Surgery _________ (type)	____	____	_________
Ventral Hernia	____	____	_________	Back Surgery	____	____	_________
Incisional Hernia	____	____	_________	Wound Infection	____	____	_________
Hysterectomy/Oophorectomy	____	____	_________	Anesthesia Complication	____	____	_________
Coronary Catheterization	____	____	_________	Bariatric Surgery	____	____	_________
Coronary Artery Bypass	____	____	_________	Breast	____	____	_________
Pacemaker	____	____	_________	Other: ___________________________			_________

Family History	Yes	No	Relationship (include maternal or paternal)
Breast Cancer	____	____	______________________________
Colon Cancer	____	____	______________________________
Other Cancer _____________ (type)	____	____	______________________________

Social History

Smoking status ❑ Never ❑ Past smoker ❑ Current smoker Packs per day _______

Alcohol ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Marijuana ❑ No ❑ Yes

Other drugs ❑ No ❑ Yes Type _______________

Current Symptoms	Yes	No
Fever, Chills, Sweats	____	____
Loss of appetite, loss of weight	____	____
Chest pain, shortness of breath, rapid or irregular heartbeat, fainting spells	____	____
Persistent cough, coughing up blood, difficulty breathing	____	____
Headache, dizzy spells	____	____
Nausea, vomiting blood, jaundice	____	____
Bladder infection, blood in urine	____	____
Swollen lymph nodes	____	____
Change in bowel habits	____	____
Breast mass/abnormality	____	____