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 Signature) (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 **Dose**
If you do not take any medication write none

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Allergies to Medication **Reaction**
If you do not have any medication allergies write none

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	____	____