SOUTHERN NEVADA SURGERY SPECIALISTS

Name ____ Date of Birth_______/_______/__________
(Last) (First) (Middle Initial)

SS# ____________________ Primary Phone ____________________ Secondary Phone ____________________

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

Email Address ____

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. 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)

CASH PATIENTS ONLY: I have read and understand the above statements. I further understand that, if the account becomes delinquent, all discounts given to me by Southern Nevada Surgery Specialists become void and the full balance must be paid.

____
(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: ____________

Are you interested in learning more about weight loss surgery: Yes _____ No _____

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

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

Family History	Yes	No	Relationship
Breast Cancer	____	____	______________________________
Colon Cancer	____	____	______________________________
Other Cancer	____	____	______________________________

Current Medications **Dose**
If you do not take any medication write none

	Medication	Dose
1.	______	______
2.	______	______
3.	______	______
4.	______	______
5.	______	______
6.	______	______
7.	______	______

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

	Allergy	Reaction
1.	______	______
2.	______	______
3.	______	______

Social History

Smoking status	❑ Never	❑ Past smoker	❑ Current smoker	Packs per day ________	
Alcohol	❑ None	❑ Occasional	❑ Moderate	❑ Heavy	
Marijuana	❑ Yes	❑ No			
Other drugs	❑ Yes	❑ No	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	____	____