

# Desert West Surgery

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## 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**
- **XRAY/ 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/DAY:** \_\_\_\_\_

**TIME:** \_\_\_\_\_

### **LOCATION:**

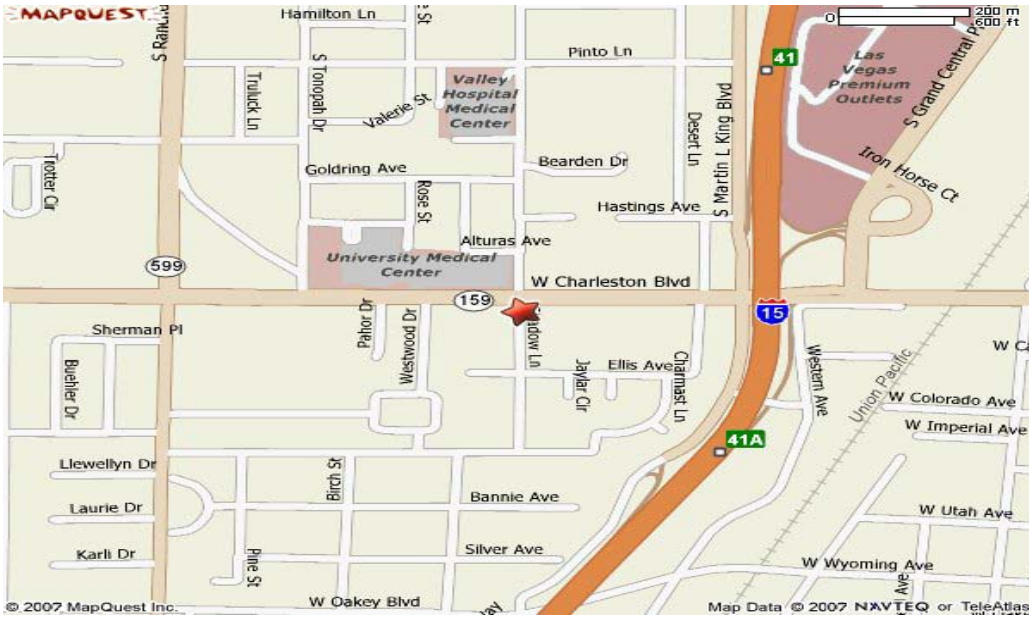
\_\_\_\_\_ **1111 SHADOW LANE, LAS VEGAS, NV 89102**

\_\_\_\_\_ **7200 CATHEDRAL ROCK DR. STE. 250, LAS VEGAS, NV 89128**

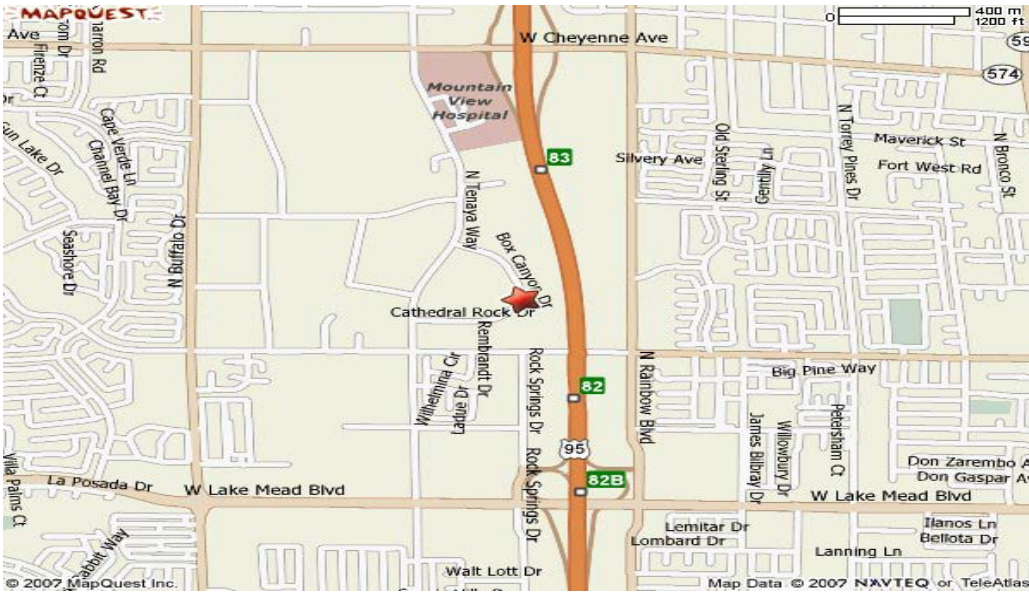
\_\_\_\_\_ **5375 S. FORT APACHE RD. STE. 101, LAS VEGAS, NV 89148**

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

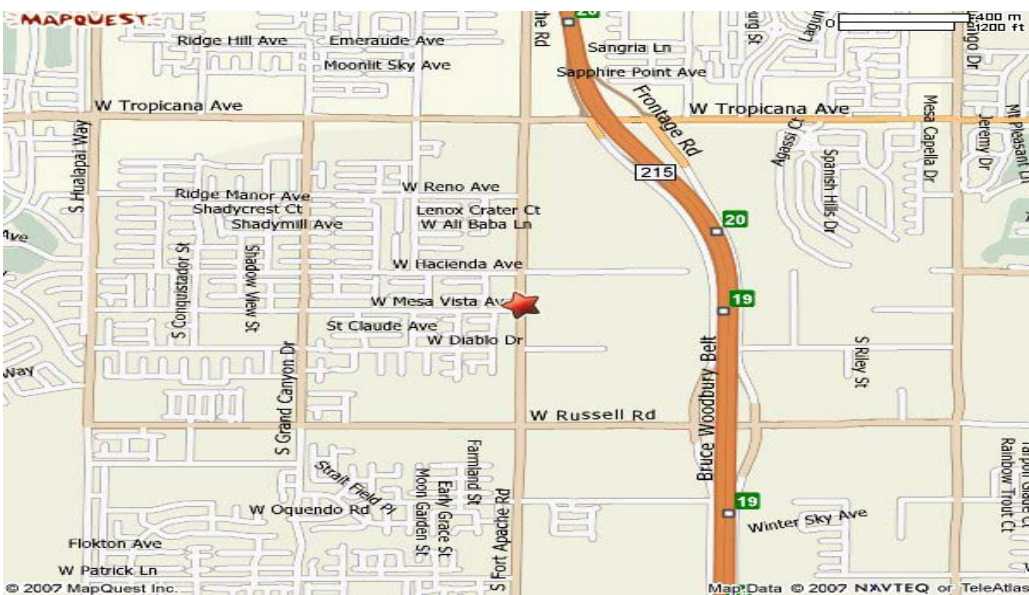
Thank you!



1111 Shadow Ln.  
Las Vegas, NV 89102



7200 Cathedral Rock Dr. Ste. 250  
Las Vegas, NV 89128



5375 S. Fort Apache Rd. Ste. 101  
Las Vegas, NV 89148

# Desert West Surgery

## Patient Information

Your Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_

Gender:  Male  Female Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Divorced  Married  Separated  Single  Widowed  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

Race:  American Indian/Alaskan Native  Asian  Black or African American  
 Native Hawaiian/Other Pacific Islander  White  Other Race

Ethnic Group: \_\_\_\_\_ Language: \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_  Home  Cellular  Work

2nd Phone Number: \_\_\_\_\_  Home  Cellular  Work

Email 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

Referring/Primary Doctor: \_\_\_\_\_

Dr. Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Insurance Coverage Information

**Primary** Insurance Name: \_\_\_\_\_

Address to send claims: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employers Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary** Insurance Name: \_\_\_\_\_

Address to send claims: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employers Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Patient's Medical History

For office use:

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

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  Immunosuppression  HIV

**Psychiatric:**  Anxiety  Depression  Suicidal Thoughts

**Breast/Skin:**  Breast Mass  Breast Skin Changes  Breast Tenderness  Nipple Discharge  Fungal Nail Infection   
Jaundice

**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 indicate this by printing “**ALL PERSONS DENIED**”.

1. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

3. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

4. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

5. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

6. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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)

Sign: \_\_\_\_\_

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.

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Legal Representative/Other

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Reason Patient is Unable to Sign

\_\_\_\_\_  
Witness

**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.

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Signature of Patient or Legal Guardian

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Print Patient's Name & Date

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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 or 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.