Las Vegas Regional Surgery Center
3560 East Flamingo Road, Suite 105
Las Vegas, Nevada 89121-5000

PATIENT INFORMATION

Patient Name: SS#

Address: City: State: Zip:

Driver License #: State: Gender: ☐ Male ☐ Female

Date of Birth: Age: Marital Status: Home Phone: ( ) Cell Phone: ( )

Email Address:

Employer: Business Phone: ( )

Business Address City: State: Zip:

INSURANCE/PAYMENT INFORMATION:

Type of Payment: ☐ Insurance *(attach photocopy of information)* ☐ Cash ☐ Lien *(attach Lien document)*

Primary Insurance _____ Policy #:_____ Policy Holder: _____

Secondary Insurance _____ Policy #: _____ Policy Holder: _____

Name of Policy Holder: DOB: SS#

Policy Holder Home Phone: ( ) *(if patient is minor)* Parent Driver License# State

Policy Holder Employer: Business Phone: ( )

Adult Patient Printed Name: *Relationship to Patient

Patient or Responsible Adult Signature: Date:

**If signed by person other than patient*

Interpreter Signature: Print Name

Interpreter relationship to patient (if applicable)

EMERGENCY CONTACT

Contact Name Telephone #: ( ) Relationship:

We will be contacting you after your procedure to check on your recovery. Where can we reach you the evening of or day after your procedure? (_____) _____--_____

To be filled out by the person accepting financial responsibility for the patient for whom you have NO legal responsibility.

I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. Please fill in all sections below and sign where indicated.

Last Name: First M.I. SS#:

Relationship to Patient: Home phone: Date of Birth:

Address: City State Zip

Driver License OR other photo ID: # Type of ID: State issued:

Occupation: Employer: Bus Phone:

Signature: **Print Name:**

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NOTICE OF PRIVACY PRACTICES/PT. RIGHTS/OWNERSHIP

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS/OWNERSHIP NOTIFICATION

I acknowledge that I was provided a copy of the Notice of Privacy Practices, Patient rights and ownership notification.

I acknowledge that I have read, or have had the opportunity to read this notice and I understand this Notice.

_____

Patient's or Authorized Representative's Signature

_____

Authorized Representative (Please print if applicable) Relationship to Patient

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

☐ Home telephone: _____
- ☐ OK to speak to :_____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Other _____

ADVANCE DIRECTIVES

Las Vegas Regional Surgery Center will respect the Advanced Directive. However the Center will NOT implement the DNR request. If you bring a copy of an advance directive or living will, a copy will be made and placed in your medical record. Should the need for a transfer to a hospital occurs, this copy would be forwarded to the hospital of transfer and they may honor these directives.

The law does not require that patients have or make an advanced directive.

☐ Yes, I have provided Las Vegas Regional Surgery Center with a copy of my Advance Directive/ Living Will. The Center has explained to me their policy regarding the honoring of this document and I agree to proceed with the proposed procedures as scheduled.

☐ Yes, I have an Advanced Directive/Living Will, but I did not bring it to the Center. (There is no requirement that you bring it to the surgery center.

☐ I do not have an Advanced Directive/Living Will. I request the facility provide me with information about Advanced Directives. I understand that Las Vegas Regional Surgery Center will not implement an Advanced Directives, but will transfer this document with me should the need arise.

☐ I DO NOT have an Advanced Directive/Living Will. I DO NOT want information.

X _____

Patient's or Authorized Representative's Signature Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient Date

Office Use Only

Information and Forms Provided to Patient: ☐ Yes ☐ No If NO please comment:

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Patient Questionnaire: Please answer the following questions Yes or No

Do you now have, or have you ever had or been treated for, any of the following conditions, illnesses, diseases or symptoms?

CARDIOVASCULAR	Yes	No	Date Year
1. High Blood Pressure / Hypertension	___	___	____
2. Heart Attack / Myocardial Infarction	___	___	____
3. Angina / Chest Pain	___	___	____
4. Heart Bypass / Stent / Angioplasty	___	___	____

RESPIRATORY			
	___	___	____
14. Abnormal Chest X-ray / TB	___	___	____
15. Asthma / Reactive Airway Disease	___	___	____
16. Bronchitis: Acute Chronic	___	___	____
17. Emphysema / COPD	___	___	____
18. Recent Cold or Respiratory Infection (During the Last 4 Weeks)	___	___	____
19. Shortness of Breath at Rest	___	___	____
20. Shortness of Breath With Exertion	___	___	____
	___	___	____

Comments:

NEUROLOGICAL	YES	No	Date Year
8. Stroke / CVA	___	___	____
9. Seizures / Convulsions	___	___	____
10. Depression	___	___	____
11. Anxiety	___	___	____

	Yes	No	Date Year
21. Cough (With or Without Sputum Production)	___	___	____
22. Sleep Apnea	___	___	____
23. C-pap machine setting	___	___	____
24. Do you smoke?	___	___	____
ENDOCRINE	___	___	____
25. Diabetes Type I Type II	___	___	____
26. Thyroid Disease or Surgery	___	___	____
	___	___	____

Comments:

HEMATOLOGIC / ONCOLOGIC	Yes	No	Date Year
27. Bleeding Easily (Gums, Nose)	___	___	____
28. Easy Bruising	___	___	____
29. Anemia (Low Blood or Low Blood Count)	___	___	____
30. HIV positive	___	___	____
31. Blood Clots: Legs Lungs	___	___	____
32. Hepatitis of any kind	___	___	____
33. Chemo / Radiation Therapy	___	___	____

Comments:

MUSCULOSKELETAL	Yes	No	Date Year
34. Arthritis: Osteo Rheumatoid	___	___	
35. Metal Implants of any kind	___	___	____
36. Neck / Back Surgery or Fusion(s)	___	___	____
37. Paresthesias / Weaknesses	___	___	____
38. Diseases of the Muscles	___	___	____

Comments:

GASTROINTESTINAL	Yes	No	Date Year
39. Alcoholic Liver Disease	___	___	____
40. Acid Reflux - GERD - Heartburn	___	___	____
41. Difficulty Swallowing	___	___	____

Comments:

URINARY / REPRODUCTIVE	Yes	No	Date Year
42. Urinary / Kidney disease	___	___	____
43. Hemodialysis	___	___	____
44. Kidney Stones	___	___	____

Have you or any of your family had any unusual reaction to Anesthesia? Y__ N___

Please list **ALL MEDICATIONS** and dosages you are *currently* taking. (Please include Over the Counter and Herbal Medicines.)
How many times per day and route taken?
Last time meds were taken?

1.
2.
3.
4.
5.
6.
7.
8.
9.

Please list ALL ALLERGIES. (Drugs and Foods) Of *special importance* are Egg, Nuts, Latex, Soy, and Sulfite Preservative allergies – list reaction

1.
2.
3.
4.
5.
6.
7.
8.
9.

Surgical History:

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PATIENT PRE-OP INSTRUCTIONS FOR THE PLASTIC SURGERY PROCEDURE

Please review the following list of instructions prior to coming to Las Vegas Regional Surgery Center for your procedure.

For Check-in:

□ Nothing to eat or drink after Midnight the night prior to your surgery

□ Please clarify with Dr.'s office if you are taking blood pressure or diabetic medications for instructions of usage on the day of surgery.

□ Wear loose clothing and slip on shoes

□ Remove all jewelry prior to coming for surgery

□ Shower before coming to the surgery Center,
* NO lotions, creams, hairspray, make-up, or fingernail polish of any kind
* NO contact lenses or tampons

□ Bring a list of your medications

□ Bring your insurance card and picture ID

□ Have a ride already arranged as you will not be able to drive yourself home, if your ride is not with you when you check in you will not be taken in for surgery until your ride has been verified by LVRSC staff. You will NOT be released to take a cab/bus home; you must have a responsible adult that will be with you for 24 hrs. after having surgery.

□ If you use or should use a C-PAP/Bi-PAP machine at bed time, bring your C-PAP /Bi-PAP machine with you

_____ _____

Patient signature: Witness signature:

**If you have any additional questions, please feel free to contact the surgery center @ 702-454-8712

**You will receive a phone call from the surgery center the day before your scheduled procedure to go over all instructions.

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LATEX ALLERGY
PATIENT QUESTIONNAIRE

Patient Name: _____ MR#: _____

		Yes	No
1.	Have you ever had allergies, asthma, hay fever, eczema or problems with rashes?	❑	❑
2.	Have you ever had anaphylaxis or an unexplained reaction during a medical procedure?	❑	❑
3.	Have you ever had swelling, itching or hives on your lips or around your mouth after blowing up a balloon?	❑	❑
4.	Have you ever had swelling, itching or hives on your lips or around your mouth during or after a dental examination or procedure?	❑	❑
5.	Have you ever had swelling, itching or hives following a vaginal or rectal examination or after contact with a diaphragm or condom?	❑	❑
6.	Have you ever had swelling, itching or hives on your hands during or within one hour after wearing rubber gloves?	❑	❑
7.	Have you ever had a rash on your hands that lasted longer than one week?	❑	❑
8.	Have you ever had swelling, itching or hives after being examined by someone wearing rubber or latex gloves?	❑	❑
9.	Have you ever had swelling, itching or hives, running nose, eye irritation, wheezing or asthma after contact with any latex or rubber product?	❑	❑
10.	Has a physician every told you that you have rubber or latex allergy?	❑	❑
11.	Are you allergic to bananas, avocados or chestnuts?	❑	❑
12.	Are you presently on beta blockers? (Heart medications)	❑	❑

Signature: _____ Date: _____