Thank you for choosing Nevada Surgery & Cancer Care. In order to serve you properly, we will need the following information. All information will be kept strictly confidential.

PLEASE PRINT

Patient's Name _____ Birth Date _____ S.S. Number _____

Home Address _____ City/State/Zip _____

☐ _____ Home Phone ☐ _____ Cell Phone

(Please indicate which number you would like us to call first by checking the appropriate box above)

Email Address _____

Race _____ (for example: Caucasian, Hispanic, African-American, Asian)

With whom can we leave a message for you? _____ ( ) Do not leave a message

Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation _____ Name of Employer _____

Address _____ Business Phone _____

Do you have Medical Insurance? ( ) YES ( ) NO If not, how do you intend to pay? _____

Primary Insurance _____ Subscriber Name _____ ID/Policy Number _____

Secondary Insurance _____ Subscriber Name _____ ID/Policy Number _____

Do you have a referral? ( ) YES ( ) NO From Whom? _____

Name of Spouse _____ Birth Date _____ S.S. Number _____

Name and Address of Spouse's Employer _____ Business Phone _____

Nearest friend or relative not residing with you _____ Relationship _____ Phone Number _____

Please read and sign the following: I directly assign all medical/surgical benefits to Nevada Surgery & Cancer Care and understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all the information necessary to secure the payment of my benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature _____ Date _____

By Typing your full name you are electronically signing this form

REVIEW OF SYSTEMS

○NEW PATIENT ○ RETURN VISIT DATE_____

PATIENT'S NAME_____

TODAY'S MAIN COMPLAINT_____

FOR RETURN VISITS, LIST NEW/CHANGED MEDICATION_____

FOR RETURN VISITS, HAVE YOU HAD ANY NEW SYMPTOMS SINCE YOUR LAST VISIT?_____

IF YES, SPECIFY_____

PLEASE CHECK ONLY THOSE THAT APPLY

GENERAL
- ○ Weight loss? How much?_____
- ○ Decrease in energy
- ○ Decrease in appetite
- ○ Night sweats
- ○ Difficulty sleeping
- ○ Heat intolerance
- ○ Fever if so, how high?_____
- ○ Diabetic

HEAD, NECK EARS, NOSE, THROAT
- ○ Sinus infection/pain
- ○ Ear pain
- ○ Ringing in ears
- ○ Change in hearing
- ○ Eye pain
- ○ Blurred vision
- ○ Change in vision
- ○ Nasal discharge
- ○ Throat pain
- ○ Stiff neck
- ○ Lumps in neck

CARDIAC
- ○ Chest pain
- ○ Irregular heartbeat
- ○ Shortness of breath on exertion
- ○ Nighttime shortness of breath
- ○ Fatigue
- ○ Decrease in ability to exert oneself

RESPIRATORY
- ○ Coughing up blood
- ○ Cough or change in cough
- ○ Mucous product with cough
- ○ Shortness of breath when lying down
- ○ Wheezing

PSYCHIATRIC
- ○ Change in mood
- ○ Change in behavior with family
- ○ Change in ability to think
- ○ Losing track of where one is, the time it is or who one is

HEMATOLOGIC
- ○ Nosebleeds, easy bruising or bleeding at other sites

EXTREMETIES
- ○ Redness of a limb
- ○ Swelling of a limb, Discoloration of a limb
- ○ Pain in legs when walking

GENITOURINARY
- ○ Burning with urination
- ○ Blood in urine
- ○ Increase in need to urinate (day or night)
- ○ Incontinence of urine
- ○ Discharge from penis/vagina
- ○ Pain with sexual intercourse
- ○ Number of pregnancies

MUSCULOSKELETAL
- ○ Arthritis
- ○ Chronic back pain
- ○ New back pain
- ○ Bone pain
- ○ Muscle soreness
- ○ Recent trauma or fractures

SKIN
- ○ Infections
- ○ Ulcers
- ○ Rashes

NEUROLOGICAL
- ○ Headaches
- ○ Change in ability to feel things
- ○ Painful sensations
- ○ Decrease in muscle strength
- ○ Decrease in ability to ambulate
- ○ Fainting
- ○ Convulsions

GASTROINTESTINAL
- ○ Pain or difficulty swallowing food
- ○ Indigestion/Heartburn
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Abdominal pain
- ○ Black stools
- ○ Blood from the rectum
- ○ Constipation
- ○ Incontinence of stool
- ○ Food intolerance
- ○ Jaundice (yellow skin or eyes)

PATIENT SIGNATURE_____

By Typing your full name you are electronically signing this form

NEVADA SURGERY & CANCER CARE AGE_____

NAME_____ DATE_____

Reason for Today's visit_____

GYN HISTORY (FEMALES ONLY)

Date of last period_____ Date of last Pap smear_____
Do you have a period every month? ☐ Yes ☐ No How many days?_____
Are your periods painful? ☐ Yes ☐ No Do you have bleeding between periods? ☐ Yes ☐ No
Do you have a history of abnormal Pap smears? ☐ Yes ☐ No Are you currently sexually active? ☐ Yes ☐ No
Do you desire more children? ☐ Yes ☐ No Do you use birth control? ☐ Yes ☐ No
Have you gone through menopause? ☐ Yes ☐ No Date of your last mammogram_____

OB HISTORY (FEMALES ONLY)

Number of pregnancies_____ (List all pregnancies, including those that ended in miscarriage/abortion)
Number of living children_____ Number of vaginal deliveries_____

List any medications, including herbal and vitamins, you currently take:

MEDICATION	DOSE	FREQUENCY

Please continue medication list on back of sheet if necessary
Medication allergies_____

MEDICAL HISTORY

	YES	NO		YES	NO
Blood clots in legs or lungs			Elevated blood pressure		
Cancer			Heart disease		
Uterus			Migraine headaches		
Colon			Osteoporosis		
Ovaries			Stroke		
Breast			Thyroid disease		
Cervix			Kidney disease		
Diabetes			Other		

Has an immediate family member had any of the above? ○ Yes ○ No If yes, what?

_____

_____

Have you ever had a colonoscopy? ○ Yes ○ No If so, when?_____

SURGICAL HISTORY

SURGERY	DATE	SURGERY	DATE

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how much?_____ Drink? ☐ Yes ☐ No
If yes, how much? _____ Recreational drugs? ☐ Yes ☐ No If yes, please list

_____

_____

Nevada Surgery and Cancer Care

Lynn Kowalski, M.D.
Stephanie Wishnev, M.D
Ren Yu Zhang, M.D.
Tuan Khuu PA-C

6020 S. Jones Blvd
Las Vegas, Nevada 89118
Phone (702) 739-6467
Fax (702) 733-1689

PRIVACY PRACTICE ACKNOWLEDGEMENT

I, _____ Have been given the option to receive a copy of Nevada Surgery and Cancer Care Notice of Privacy Practices.

_____ Yes I would like a copy of Notice of Privacy Practices.

_____ No I do not need a copy of Notice of Privacy Practices but can request a copy at any time.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

By Typing your full name you are electronically signing this form

Nevada Surgery & Cancer Care

PLEASE READ THIS IMPORTANT INFORMATION

Please initial that you have reviewed and read below

- Please allow 72 hours for prescription refill.____
- If you cannot make appointment and do not call our office to cancel or reschedule within 24 hours you will be charged a $50.00 missed appointment fee. ____
- There is a $35.00 fee for returned checks. ___
- **As a courtesy, Nevada Surgery and Cancer Care will verify your insurance coverage We will also bill your insurance on your behalf and only collect the amount deemed your responsibility by your insurance plan.If after verification with your insurance company it is determined your plan is out of network, you will be responsible for your copay, deductible and co-insurance at the time of service.____**
- The verification we receive from your insurance plan is not a guarantee of benefits or payment. We recommend that you also verify your medical benefits with your insurance company._____
- All Copays, Deductibles and Co-Insurances are payable at the time of service._____
- If you are dropping off disability, FMLA forms or any documents requiring processing please be aware there is a $25.00 charge for each form. All forms received by 12:00pm on Wednesday will be completed by 3:00pm on Friday. If your form was received after 12:00pm on Wednesday will be completed on the following Friday. ___
- I (or patient's guardian, if minor) understand that I am ultimately responsible for payment of the treatment and care. ___
- **I will provide the most current and updated information about my insurance, and will be responsible for charges incurred if the information provided is not correct. ___**
- For patients of Dr. Zhang and Dr. Wishnev : during your exam a device called an anoscopy could be used to better diagnose your condition. Please be aware that this will be a separate charge billed to your insurance company and you could have some financial responsibility._____

I,_____ have read and understand the information
(Print Patient Name)
Listed above.

Patient Signature _____ Date _____

By Typing your full name you are electronically signing this form

NEVADA SURGERY & CANCER CARE
6020 S. JONES BLVD
LAS VEGAS NV 89118
702-739-6467
702-733-1689 FAX

I, _____ authorize Nevada Surgery & Cancer Care to release medical information, in both written and verbal formats to the following individuals:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Print Patient Name

_____

Signed

_____

Date

By Typing your full name you are electronically signing this form

Nevada Surgery and Cancer Care

Lynn Kowalski, M.D.
Stephanie Wishnev, M.D
Ren Yu Zhang, M.D.
Tuan Khuu PA-C

Medical Records Release Form

I, _____ Hereby authorize DR. _____

At phone number _____

And fax number _____ to release my medical records to:

Nevada Surgery and Cancer Care
6020 S Jones Blvd
Las Vegas, NV 89118

Phone : (702) 739-6467 Fax Number: (702) 733-1689

Please release the following requested records:

_____

_____

_____

Print Name: _____ Date: _____

Signature: _____ Date of Birth: _____

By Typing your full name you are electronically signing this form

NVSCC
Nevada Surgery & Cancer Care

Patient Pharmacy Preference Form

Date:_____

Patient Name:_____

Your physician will send any prescription for medications electronically to the pharmacy you designate.

You may update or change this information at any time.

Please indicate which pharmacy you would like to use:

Local Pharmacy: _____

Address:_____

Phone Number:_____

By Typing your full name you are electronically signing this form

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	----	--	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE/ENDOMETRIAL CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐Y ☐N Are you of Ashkenazi Jewish descent?

☐Y ☐N Are you concerned about your personal and/or family history of cancer?

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome* *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome* *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

RFCFHQ/11-12

By Typing your full name you are electronically signing this form