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

Personal Information

Full Name: ______________________________ **Preferred Name**: ____________________

Date of Birth (MM/DD/YYYY): __________**Social Security Number (SSN)**: ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: Street: ____

City: _____________________ State: _______ ZIP Code: _______

Phone Number (Home): __________________**Phone Number (Cell)**: __________________

Email Address: ____

Race: ☐ Asian ☐ Black or African American ☐ White ☐ Native American ☐ Pacific Islander

☐ Other: ____________

Preferred Language: __________________ **Interpreter Needed**: ☐ Yes ☐ No

Employer Name: _______________________ **Occupation**: _________________________

Work Phone Number: ___________________

Do you have Medical Insurance? ___ Yes ___ No If not, how do you intend to pay? ________

Primary Insurance Provider: ______________ **Insurance Policy Number**: ________________

Policyholder's Name: ____________________ **Policyholder's Date of Birth**: ______________

Secondary Insurance Provider: _____________ **Insurance Policy Number**: ______________

Policyholder's Name: ____________________ **Policyholder's Date of Birth**: ______________

Emergency Contact Full Name: _______________________ **Relationship to Patient**: _______

Phone Number: ______________________ **Alternate Phone Number**: _______________

Consent and Acknowledgment

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 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.

Patient Signature: ____________________________________ **Date**: _________________

PLEASE MAKE SURE THESE TWO PAGES ARE FILLED OUT COMPLETELY

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 (you can use the back sheet of this page if needed):

MEDICATION	DOSE	FREQUENCY

Medication allergies: ____

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

____

____

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		

Have you ever had a colonoscopy? ( ) Yes ( ) No If so, when? ________________________________

SURGICAL HISTORY – *PLEASE RECORD EVERY SURGERY YOU HAVE HAD OVER YOUR LIFETIME. PLEASE INCLUDE C-SECTIONS (you may use the back of this page if needed):*

SURGERY	DATE

Review of Systems (ROS)

( ) 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 ____

GENERAL
☐ Unexplained weight loss? How much? _______
☐ Decrease in energy
☐ Decrease in appetite
☐ Night Sweats
☐ Difficulty sleeping
☐ Heat intolerance
☐ Fever – is 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, time it is or who one is

HEMATOLOGIC
☐ Nosebleeds, easy bruising or bleeding at other sites

EXTREMETIES
☐ Redness of 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
☐ Painful 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

GASTROINTESTNAL
☐ Pain or difficulty swallowing food
☐ Indigestion/Heartburn
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Abdominal pain
☐ Black stools
☐ Blood from the rectum
☐ Constipation
☐ Incontinence of stool
☐ Food intolerance

Patient's Signature: ____

THIS FORM IS FOR DR. ZHANG PATIENTS ONLY!!!!

NEVADA SURGERY AND CANCER CARE

☐ **New Patient** ☐ **Follow up** ☐ **Post-op** ☐ **Procedure** **DATE:** ____________

PATIENT'S NAME: ______________________ DOB: ____________

MAIN COMPLAINT: ______________________

FOR RETURN VISITS, LIST NEW/CHANGED MEDICATION: ______________________

FOR RETURN VISITS, ANY NEW SYMPTOMS SINCE YOUR LAST VISIT? IF SO, PLEASE 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
- ☐ Decrease in ability to exert onself
- ☐ Fatique

RESPIRATORY

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

HEMATOLOGIC

- ☐ Nosebleeds, easy bruising or bleeding at other sites

PSYCHIATRIC

- ☐ Change in mood/ability to think
- ☐ Change in behavior with family
- ☐ losing track of where/who is

EXTREMETIES

- ☐ Redness of a limb
- ☐ Swelling/Discoloration of limb
- ☐ Pain in legs when walking

GENITOURINARY

- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Increase to urinate
- ☐ 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 fracture

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

For office use only	
WT:	
BMI:	
HT:	
B/P:	
SPO2:	
P:	
PAIN LEVEL:	
TEMP:	

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: ____

Please indicate if you also have a mail in pharmacy:

Mail In Pharmacy: ____________________________________

Address: ____

Phone Number: ____

PLEASE READ THIS IMPORTANT INFORMATION

Please initial that you have reviewed and read below

______ *Please allow 72 hours for prescription refill.

______ *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 deferred 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 due at the time of service.

______ *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.

______ *During your visit at Nevada Surgery and Cancer Care you are free to request a chaperone from one of our medical staff.

______ *For patients of Dr. Wishnev and Dr. Zhang 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 listed above.

____ ___________________________

Patient Signature Date

Effective Date: June 1st, 2024

At Nevada Surgery and Cancer Care, we are committed to providing high-quality healthcare services to our patients. To maintain the efficiency of our operations and ensure fair compensation for the services we provide; we have established the following policy regarding the below practice fees:

______**No Show Fee:** A "no show" occurs when a patient fails to attend a scheduled appointment without providing at least 24 hours' notice of cancellation or rescheduling. In the event of a true no show, the patient will be charged a fee of $100. This fee is intended to cover the costs incurred by the missed appointment and the time reserved for the patient. All cancellations or rescheduling of appointments need to be done by contacting the office at 702-739-6467 and speaking to a live person or via email to **info@nvscc.com.** Cancellations made by leaving a voicemail on a particular extension or calling into to the answering service after hours, may result in the fee still being applied to the patient's account.

_______**Medical Records Fee:** Patients or authorized individuals requesting copies of medical records will be charged a fee of $.60 per page. This fee covers the administrative costs associated with copying and processing medical records requests.

_______**Surgery Cancellation Fee:** Patients who cancel a scheduled surgical procedure without 3 business days' notice will be charged a fee of $300. This fee is intended to cover the costs associated with rescheduling the surgery and the loss of operating room time. All cancellations or rescheduling of appointments need to be done by contacting the office at 702-739-6467 and speaking to a live person or via email to **info@nvscc.com.** Cancellations made by leaving a voicemail on a particular extension or calling into to the answering service after hours, may result in the fee still being applied to the patient's account.

______**FMLA/Disability/Misc Forms Fee:** Patients requesting completion of certain forms will be charged a fee of $50 per form. This fee covers the administrative time and resources required to complete and process FMLA paperwork.

______**Returned Check Fee:** In the event of a returned check due to insufficient funds or other reasons, the patient will be charged a fee of $35 to cover the administrative costs and bank fees associated with processing the returned check.

_______**Payment Process:** Fees incurred by patients will be added to their account and must be paid in full within 30 days of receiving the invoice or before scheduling another appointment. Failure to pay fees in a timely manner may result in additional collection efforts as well as being discharged from the practice.

_______**Appeals Process:** Patients who believe a fee has been charged in error or have extenuating circumstances may submit an appeal to have the fee waived or reduced. Please submit all appeals in writing to **info@nvscc.com**. Appeals will be reviewed by Nevada Surgery and Cancer Care management on a case-by-case basis, and decisions will be made at their discretion.

________**Communication**: We will clearly communicate our practice fees policy to all patients through various channels, including our website, patient registration forms, and in-person interactions. This ensures that patients are aware of their financial responsibilities and the consequences of failing to meet them.

By implementing this policy, we aim to maintain the efficiency of our operations while providing transparent and fair pricing to our patients.

Thank you for your cooperation and understanding,

Nevada Surgery and Cancer Care Management

____________________________________	____________________
Patient Signature	Date
____________________________________	____________________
Witness	Date

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
X 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, either in one relative or in two or more relatives on the same side of the family
- ☐ 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:__________

Lynn Kowalski, M.D.
Stephanie Wishnev, M.D.
Ren Yu Zhang, M.D.
Josie Johnson, PA-C
6020 S. Jones Blvd. / Las Vegas, NV 89118

MEDICAL RECORDS RELEASE

Patient Name: ______________________________ **DOB:** ______________
Last 4 SSN: ______________

I, ______________________________ hereby authorize
Dr. ______________________ at phone #: ______________________
and fax #: ______________________ to release my medical records to:

Nevada Surgery and Cancer Care
6020 S. Jones Blvd. / Las Vegas, NV 89118
P#:(702)733-6467 F#:(702)733-1689

Please release the following requested records:

____
____
____
____
____

Patient Signature: ______________________________ **Date:** ______________

☐ **Standard**	☐ **Urgent**	☐ **STAT**

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