

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: _____ **Licensed 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:** _____

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

EXTREMITIES

- 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

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

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 oneself _____
- Fatigue _____

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 _____

EXTREMITIES

- 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 _____
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- 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@nvsc.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@nvsc.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@nvsc.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
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EXAMPLE: BREAST CANCER	45	-----	---	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	UTERINE/ENDOMETRIAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME COLON POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER CANCER(S) (Specify cancer type)	Among others, consider the following cancers: <i>Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid</i>						

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**

*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*

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

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: _____

<input type="checkbox"/> Standard	<input type="checkbox"/> Urgent	<input type="checkbox"/> STAT
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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