PATIENT REGISTRATION INFORMATION:

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Employer: _____ Work#: _____

Cell#: _____ Social Security #: _____ Gender: ☐ Male ☐ Female

Marital status: ☐ Married ☐ Single ☐ Widow/er ☐ Divorced

Primary Physician: _____ Referring Doctor: _____

SPOUSE OR PARENT INFORMATION:

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Work#: _____ Cell#: _____

Employer: _____ Employer Phone#: _____ SS#: _____

INSURANCE INFORMATION:

Name of Insurance: _____ Name of Policy Holder: _____

Insurance ID#: _____ Group #: _____ Employer: _____

Policyholder DOB: _____ SS#: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE INFORMATION:

Name of Insurance: _____ Name of Policy Holder: _____

Insurance ID#: _____ Group #: _____ Employer: _____

Policyholder DOB: _____ SS#: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMERGENCY CONTACT: (NOT LIVING WITH YOU) _____

Relationship to you: _____ Home#: _____ Cell#: _____

ADDITIONAL INFORMATION

CALLS & MESSAGES:

You can leave messages at home	☐ Yes	☐ No
You can leave messages at work	☐ Yes	☐ No
You can leave message on cell	☐ Yes	☐ No
You may email me at above email	☐ Yes	☐ No
You may access my RX external history	☐ Yes	☐ No

Appointment Reminder ☐ Home ☐ Cell ☐ Work

Email: _____

Requested PHARMACY: _____ Requested Laboratory: _____

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ American Indian ☐ African American ☐ Pacific Islander ☐ Other

I hereby consent for treatment and give authorization for payment of insurance benefits to be made directly to Carson Surgical Group and any assisting physicians for services rendered. The above information I have provided is current an accurate. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release any information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as original

Signature: _____ Date _____

Timothy J. King, M.D. FACS Kevin D. Halow, M.D. MBA, RVT, FCCP, FACS
Shannon H. Beal, M.D. RPVI Tania J. Dickson-Humphries, PA-C
Allison T. Adams, PA-C Carrie Davidson, PA-C

WELCOME TO OUR OFFICE

Thank you for choosing Carson Surgical Group for your medical care. We are committed to providing care, which is efficient, courteous and competent.

Please understand that payment, accurate billing and collections of your bill are considered a part of your treatment. Necessary forms need to be completed to expedite carrier payment. It is your responsibility to provide us with your most current insurance information.

Please bring: Insurance card(s), Picture ID, Medication list, Surgical history

OUR FINANCIAL POLICY: (Please take time to read)

1) If you have a balance with us after your insurance has paid you are required to pay the balance in full within 30 days of your first statement.

2) If you have not paid within 90 days and have NOT made payment arrangements your account will be referred out.

3) When your account is referred to an outside collection agency your balance will be increased by 50% for collection processing. This can and will impact your financial credibility. This is a substantial amount added to your current balance.

4) If you are scheduled for ultrasound(s) or Office surgery and do not provide at least 24 hour notice of cancellation you will be charged $200.00 as a no show fee.

5) If you reschedule more than two (2) times for ultrasounds or an office surgery with less than 24 hour notice you will not be rescheduled.

If you know that you will need assistance paying your balance in full contact us immediately. We will work with you but you must contact us to make these arrangements.

Disclosure:

I understand that if my insurance carrier denies any charges or I have no insurance to file for services I am responsible for the bill. I have read the financial policy and understand my responsibility. I am responsible for any deductibles, co-payments or co-insurance at the time of service.

Signature:_____ Date:_____

HEALTH HISTORY QUESTIONNAIRE

Why are we seeing you today? _____

HEIGHT : _____WEIGHT: _____

Please mark if you have HAD any of the following:

- ☐ Asthma
- ☐ Arrhythmia ☐ Atrial Fibrillation
- ☐ Angina ☐ Acid Reflux
- ☐ Bleeding disorders
- ☐ Blood thinners ☐ Kidney Disease
- ☐ Cancer ☐ Chronic pain
- ☐ Congestive heart failure ☐ COPD ☐ Chest pain
- ☐ Diabetes: ☐ Insulin ☐ Oral Med ☐ Diet
- ☐ Depression
- ☐ Difficult Airway ☐ Difficult intubations
- ☐ Emphysema ☐ Food allergies ☐ GERD
- ☐ Hepatitis A☐ B☐ C☐
- ☐ History of nausea/vomiting after surgery
- ☐ History of CLOTS: ☐Legs ☐Lungs ☐Arms
- ☐ HIV / AIDS
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ Unusual reaction to anesthesia (Self or family member?)
- ☐ Heart Attack: Date:
- ☐ Heart Surgery:
- ☐ Date: _____ Dr.
- ☐ Yellow / Jaundice
- ☐ Latex allergy
- ☐ Migraines ☐ Malignant Hyperthermia
- ☐ Oxygen at home: ☐ All the time
- ☐ Just at night How many liters?
- ☐ Pseudocholinesterase deficiency (sensitive to Anectine)
- ☐ Panic disorder
- ☐ Pacemaker ☐ AICD
- ☐ Renal failure ☐ Rheumatoid arthritis
- ☐ Seizures Date of last one: _____
- ☐ Sleep Apnea, Diagnosed
- ☐ CPAP use ☐ BIPAP use
- ☐ Stroke ☐ TIA
- ☐ TB ☐ Thyroid problems

Describe: _____

Are you a smoker? ☐ Yes ☐ No Packs per day _____ ☐ Cigar/Pipe How often? _____

Have you ever smoked ☐ Yes ☐ No When did you quit? _____

Alcohol Use: ☐ Yes ☐ No How often? _____ Drug Use: ☐ Yes ☐ No

Do you take ASPIRIN? 81mg or higher ☐ Yes ☐ No

Have you ever had a PNEUMOCOCCAL immunization? ☐ Yes ☐ No

Have you had a INFLUENZA vaccine this flu season ☐ Yes ☐ No

Have you had a Mammogram in the last 2 years Yes ☐ No ☐

Have you had a Colonoscopy in the last 10 years Yes ☐ No ☐

CURRENT MEDICATION (Include prescriptions, supplements & OTC)

Drug Name	Dose	Reason	Drug Name	Dose	Reason

DRUG ALLERGIES

LIST ALL PREVIOUS SURGERIES

FAMILY HISTORY:	Mother	Father		Mother	Father		Mother	Father
Breast Cancer	☐	☐	Genetic Disease	☐	☐	Prostate Cancer	☐	☐
Blood clotting problems	☐	☐	Colon Cancer	☐	☐	Bleeding Problems	☐	☐

REVIEW OF SYSTEMS: Mark squares if You, the patient, have ever experienced any of the following:

SYSTEMIC PROBLEMS
- ☐ Fever/Chills
- ☐ Loss
- ☐ Fatigue
- ☐ Night Sweats

EYES
- ☐ Episodes of blindness
- ☐ Wear glasses
- ☐ Double Vision

EARS, NOSE AND THROAT
- ☐ Hearing difficulties
- ☐ Dental Problems
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarse Throat

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Chest Pain/Pressure
- ☐ Dizzy Spells
- ☐ Short of Breath at night
- ☐ Need extra pillow to breathe
- ☐ Swollen Ankles
- ☐ Heart Murmur

RESPIRATORY
- ☐ Cough up phlegm/blood
- ☐ Shortness of breath
- ☐ Chest colds/bronchitis
- ☐ Asthma

DIGESTIVE
- ☐ Problems swallowing
- ☐ Stomach pains
- ☐ Black stools
- ☐ Constipation
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Pain in rectum
- ☐ Rectal bleeding

GENITOURINARY
- ☐ Day - or - ☐ Night frequency
- ☐ Burning in urination
- ☐ Abnormal color in urine
- ☐ Urgency

Men
- ☐ Weak stream Weight
- ☐ Prostate trouble
- ☐ Burning or discharge
- ☐ Lumps on testicles

Women
- ☐ Last menstrual period
- ☐ Post menopausal
- ☐ Abnormal vaginal bleeding
- ☐ Last PAP smear _____
- ☐ Abnormal PAP smear
- ☐ Pregnant now?

How many pregnancies _____

How many normal births _____

MUSCULOSKELETAL
- ☐ Aching muscles ☐ Aching joints
- ☐ Leg or calf pain ☐ Cramping

BREAST
- ☐ Lumps ☐ Pain ☐ Nipple discharge

SKIN ☐ Cancer ☐ Disorder: _____

NEUROLOGICAL
- ☐ Weakness ☐ Numbness
- ☐ Convulsions

PSYCHIATRIC
- ☐ Hopeless outlook
- ☐ Work/family problems
- ☐ Contemplated suicide
- ☐ Sexual difficulties

ENDOCRINE
- ☐ Abnormal thyroid
- ☐ Abnormal development

HEMATOLOGICAL / LYMPHATIC
- ☐ Lumps: ☐ Neck ☐ Armpit ☐ Groin
- ☐ Bleed easily
- ☐ Abnormal bruising

ALLERGIC / IMMUNOLOGICAL
- ☐ Unusual allergies
- ☐ Frequent infectious disease

Please list any additional information about your health or physical/mental condition that would help staff with your care:

_____

_____

_____

Signature: _____ Date: _____

HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

*Conduct, plan and direct my treatment and follow up care among the multiple healthcare providers whom may be involved in the treatment directly or indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

A COMPLETE DISCLOSURE OF THE NOTICE OF PRIVACY PRACTICES WAS OFFERED TO ME

1. Please list the family members or other person, if any, whom we may inform about your general medical condition, diagnosis, appointments, test results, or other health care information (including treatment, payment and healthcare operations). You are not required to list anyone, but if you do you are authorizing that person to have complete access to your medical and/or payment information.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

2. Our office staff will NOT leave any confidential health information on voicemail. We will only leave a call back number for your prompt attention to reach us during business hours.

3. If you have any special requests please inform our receptionist or your Health Care staff.

I have read and understand this form and agree with all statement made

Patient Signature: _____ Date: _____

Relationship to patient: _____

PATIENT NAME: _____ DATE: _____

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

☐ Never (0 points)

☐ Monthly or less (1 point)

☐ Two to four times a month (2 points)

☐ Two to three times per week (3 points)

☐ Four or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 (0 points)

☐ 3 or 4 (1 point)

☐ 5 or 6 (2 points)

☐ 7 to 9 (3 points)

☐ 10 or more (4 points)

If 'Yes' : How often did you have six or more drinks on one occasion in the past year?

☐ Never (0 points)

☐ Less than monthly (1 point)

☐ Monthly (2 points)

☐ Weekly (3 points)

☐ Daily or almost daily (4 points)

Points ☐

Interpretation

☐ Positive

☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

· In men, a score of 4 or more is considered positive.

· In women, a score of 3 or more is considered positive.

To our valued patients,

As you may already be aware, Nevada law AB 474 is now in effect. This law governs controlled substance use, abuse, addiction, and treatment of addiction. As medical providers we have been directed, by the State of Nevada, to adopt certain guidelines, procedures, and protocols when it comes to prescribing medications that are considered to be controlled substances; specifically opioids. These are any drugs whose base pain relieving formula is derived from opium. Common examples include medications such as Tylenol #3, Norco, Percocet, and Darvocet to name a few. While these medications can be very effective in both perioperative and post-operative pain control, they do have addictive and abusive potential.

The State of Nevada has challenged its medical providers to help curb the rapidly growing epidemic of opioid addiction, abuse, and overdose. At Carson Surgical Group, we have embraced the state's call to action and have adopted methods to both remain in compliance with the state law as well as assist in decreasing, and even eliminating, opioid abuse and addiction.

In this packet you will find an opioid risk assessment survey and an opioid prescription consent form. These forms must be filled out by all of our patients who require opioid treatment. **By law, we cannot prescribe opioid treatment if these are not filled out.**

We appreciate your understanding and cooperation with the new Nevada State Law directives. We do believe, that, with your help, we can make a positive impact towards containing and, eventually eliminating, the epidemic of opioid addiction and abuse in our state.

Warm Regards,

The Physicians of Carson Surgical Group

****** Please complete page 2 of this form******

CARSON SURGICAL GROUP

OPIOID RISK ASSESSMENT SCREENING TOOL

Patient Name:_____ DOB: _____

This risk assessment tool is required by the state of Nevada for all patients that are seen in our office. We are required, by law, to administer this assessment questionnaire to every patient upon an initial visit and prior to beginning opioid therapy for pain management.

The objective of the assessment tool is to determine a patient's risk for opioid addiction and/or abuse and to use that in consideration when prescribing narcotics. **This assessment screening tool is required by the law and we cannot see you unless it is filled out.**

Summary of the assessment tool:

A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies to you:

	Female	Male
Family History of Substance Abuse		
Alcohol	1	3
Prescription Drugs	2	3
Illegal Drugs	4	4
Personal History of Substance Abuse		
Alcohol	3	3
Prescription Drugs	4	4
Illegal Drugs	5	5
Patient Age		
Age less than 16	0	0
Age 16-45	1	1
Age > 45	0	0
Psychological and Social History		
History of Sexual Abuse < 12 yo	3	0
ADD, OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Total Score		