INTERNAL MEDICINE SPECIALISTS OF LAS VEGAS

New Patient Update

DATE	PLEASE ENTER THE NAME OF THE DOCTOR SEEING YOU TODAY

PATIENT INFORMATION

PATIENT NAME (LAST) (FIRST) (M.I.)					SSN:
CELL PHONE	HOME PHONE	SEX	DATE OF BIRTH	AGE	MARITIAL STATUS
ADDRESS					APT/SPACE/UNIT #
CITY		STATE	ZIP	EMAIL	
PATIENTS EMPLOYER			OCCUPATION		
EMPLOYERS ADDRESS					WORK PHONE
CITY		STATE		ZIP	

GUARANTOR INFORMATION

GUARANTOR NAME (LAST) (FIRST) (M.I.)			SSN:	PHONE NUMBER
GUARANTOR ADDRESS	CITY		STATE	ZIP
GUARANTOR EMPLOYER	OCCUPATION			WORK
GUARANTOR EMPLOYER ADDRESS	CITY		STATE	ZIP
REASON FOR VISIT	REFERRING PHYSICIAN		HOW DID YOU HEAR ABOUT OUR OFFICE?	
EMERGENCY CONTACT		PHONE		RELATIONSHIP
ADDRESS	CITY		STATE	ZIP

INSURANCE INFORMATION

1. PRIMARY INSURANCE CO.				PHONE
ADDRESS	CITY		STATE	ZIP
POLICY HOLDER NAME		DATE OF BIRTH		SSN
RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER			
POLICY #	GROUP #			EFFECTIVE DATE
2. SECONDARY INSURANCE CO.				PHONE
ADDRESS	CITY		STATE	ZIP
POLICY HOLDER NAME		DATE OF BIRTH		SSN
RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER			
POLICY #	GROUP #			EFFECTIVE DATE

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance and I assign benefits otherwise payable to me to the doctor or group indicated on the claim.
All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.
In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor. If a check is returned there will be a $25.00 NSF charge.

A copy of the signature is as valid as the original

PATIENT SIGNATURE DATE

GUARANTOR SIGNATURE DATE

Today's Date:_____

NAME:_____ SSN:_____

OCCUPATION:_____ EMPLOYER:_____

DATE OF BIRTH:_____ AGE:_____ MALE OR FEMALE

PREFERRED PHARMACY with PHONE #:_____

ALLERGIES: Please list type of allergy and reaction

Name of Drug or Type of Allergy	Reaction

CURRENT MEDICATION: Please list all medication you take and their dosages

Medication	Dosage	Medication	Dosage

PREVIOUS HOSPITALIZATIONS/SURGERIES:

Year	Hospital/City	Reason	Physician

PAST MEDICAL HISTORY: Please indicate whether you have ever had:

		Condition			Condition
Y	N	High Blood Pressure	Y	N	Asthma
Y	N	Heart Attack	Y	N	Kidney Stones
Y	N	Diabetes	Y	N	Kidney Disease
Y	N	Stomach Ulcers	Y	N	Pneumonia
Y	N	Gout	Y	N	Arthritis
Y	N	Liver Disease/Hepatitis	Y	N	Gallbladder Disease
Y	N	Thyroid Disease	Y	N	Anemia
Y	N	Psoriasis	Y	N	Increased Cholesterol
Y	N	Cancer	Y	N	Blood Transfusion
Y	N	Stroke	Y	N	Histroy Of Heart Murmur

Y N Accident/Broken Bones (please list):_____

Other Medical Condition/Problems not _____

_____

FEMALES ONLY: Are you or could you possibly be Pregnant? Y N Date of last menstrual period_____

FAMILY HISTORY: Has anyone in your family ever had the following:

		Condition	Relationship			Condition	Relationship
Y	N	Heart Condition		Y	N	Diabetes	
Y	N	Epilepsy		Y	N	Thyroid Disease	
Y	N	Stroke		Y	N	Cancer	
Y	N	Asthma		Y	N	Colitis	
Y	N	Bleeding Tendencies		Y	N	High Blood Pressure	

MARITAL STATUS:_____Married _____Divorced _____Single

Spouse: _____Alive _____Deceased

HABITS:

Do you now or have you ever smoked? Y N How much/many?_____ How long?_____

Do you drink alcohol? Y N How much?_____ How long?_____

Do you now or have you ever used illicit drugs? Y N

SYSTEM REVIEW: Please check any problems which apply to you at this time:

GENERAL

Weakness _____
Fatigue _____
Fever _____
Recent Weight Gain _____
Recent Weight Loss _____

EYES

Blurred Vision _____
Double Vision _____
Eye Drainage _____
Eye Redness _____
Eye Exam _____

HEAD, EARS, NOSE & THROAT

Headache _____
Ear Pain _____
Ear Drainage _____
Decreased Hearing _____
Nasal Congestion _____
Throat Pain _____
Hoarseness _____
Change of Voice _____

CARDIOVASCULAR

Chest Pain/Tightness _____
Irregular Heartbeat _____
Heart Murmur _____
Passing Out _____

LUNGS

Shortness of Breath _____
Cough _____
Difficulty Breathing _____
Wheezing _____

DERMATOLOGICAL

Skin Rash _____
Acne _____
Skin Itching _____
Moles _____

GASTROINTESTINAL

Nausea _____
Vomiting of Blood _____
or Black Material _____
Yellow Jaundice _____
Blood in Stool _____
Heartburn _____

GENITOURINARY

Incontinence _____
Difficulty Urinating _____
Burning with Urine _____
Blood in Urine _____
Discharge (Penis) _____

GYNECOLOGICAL

Vaginal Dryness _____
Vaginal Bleed _____
Last Menstrual Period _____

MUSCLE/JOINT/SKELETAL

Morning Stiffness _____
How Long? _____
Joint Swelling/Pain _____
Joint Affected? _____
Muscle Spasm _____

NEUROLOGICAL

Weakness _____
Headache _____
Dizziness _____
Fainting _____
Memory Loss

ENDOCRINOLOGICAL

Dry Skin _____
Coarse Hair _____
Early Menstrual _____
Cold/Heat Intolerance _____

SCREENING PROCEDURE

Date of Last Treadmill? _____
Date of Last EKG? _____
Date of Last Chest Xray? _____
Date of Last Pap Smear? _____
Date of Last Mammo? _____
Date of Last Colonoscopy? _____

Do you have a living will? Yes or No

I certify that the above information is true and accurate.

Signature: _____ **Date:** _____

INTERNAL MEDICINE SPECIALISTS OF LAS VEGAS
2010 Wellness Way #100
Las Vegas, NV. 89106

NOTICE OF PRIVACY PRACTICES

YOUR RIGHTS:
Following is a statement of your rights with respect to your protected health information.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION.
Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

YOUR HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

YOU MAY HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and become effective on/or before July 1, 2007.

We are required by law to maintain your privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME: _____ **SIGNATURE:** _____

DATE: _____

What You Should Know About Advance Directives/Living Wills/ Durable Power of Attorney

An advance medical directive (Advance Directive), commonly referred to as a **"Living Will"** or **"Health Care Directive"** is a legal document intended to ensure that a patient's wishes concerning medical treatment will prevail if the patient is terminally ill or permanently unconscious. Another type of Advance Directive is the **Durable Power of Attorney**, which is a written document that gives the authority to another, usually a spouse or relative, to make decisions for him or her self. Most physicians have encountered patient-executed Advance Directives and make every effort to comply with the patient's wishes.

Advance Directives guide your doctor in choosing appropriate medical care for you based on how you want to be treated. An Advance Directive can also be a comfort to your family and help them with difficult decisions when you are unable to speak for yourself. And they help you maintain dignity and control over your own life, even at the very end. It's always hard to make tough decisions for a loved one, but if you write down your wishes in an Advance Directive, it becomes much easier for others to honor them. And you have the right to change any of you Advance Directives at any time. Either way, you are the one who is in control.

If you already have an Advance Directive in place, please provide a copy to Internal Medicine Specialists of Las Vegas so that we may honor your wishes. However, if you do not have an Advance Directive and you would like to create one, please ask a medical provider or the administrative staff to provide you with the necessary information.

Note: This article does not provide specific legal advice and it is not intended as such

Advance Directives

Patient Notification Form

I have been given information regarding the choices I can make regarding my health care. These choices are called Advance Directives, a Living Will, or Durable Power of Attorney. I understand that in order for these directives to be valid, I need to put them in writing and have them witnessed or notarized. If I choose to make these part of my record, I will bring in a copy to the office to be included in my medical records.

_____	_____
Print Name	Date of Birth
_____	_____
Patient Signature	Date

ADVANCED CARE PLANNING

(Advance Directives)

For patients 18 and older

Advanced Care Planning refers to a process of mapping out the types of medical and non-medical care you would like to receive at some future point should a life-threatening or terminal disease make it impossible for you to express your wishes at that time. This type of planning is an ongoing process. It is a process of thoughtful discussion between you and your care providers, spouse, family, and significant others. While this conversation often results in a document it is more than just a piece of paper. It is an effort to better educate yourself about alternatives regarding the end of life and an opportunity to educate your physician, spouse, family, and others about your values, goals, and wishes related to end-of-life care. This communication between you and your health care provider can be done at any time, preferably when you are younger and still healthy. Once completed, it should be revised on a regular basis – every five years or after any potentially life-changing event, such as marriage, divorce, death of a spouse, or the onset of a life threatening disease.

Advance care planning usually produces an **Advance Directive**, which is a written document that helps to summarize the plans you have made for future care. These documents take several forms, such as a **Living Will** and a **Durable Power of Attorney for Heath Care**. While they can be completed without the involvement of you health care provider, it is much preferred to do this together. The future usefulness of these documents is better assured if your healthcare professional has been part of the planning process.

Reference: Nevada for Ethics and Health Policy

Please check one of the statements and sign below.

_____ I have an Advance Directive in effect and agree to provide a copy for my medical record.

_____ I do **NOT** have an Advance Directive in effect currently. I have read and understand the above information on Advance Directives.

Signature:_____ Date:_____

Patient's Name

Controlled Substance Questionnaire	YES	NO	N/A
N/A means not applicable.			
Have you ever used a controlled substance in a way other than prescribed?	____	____	____
Have you ever diverted a controlled substance to another person?	____	____	____
Have you ever taken a controlled substance that did not have the desired effect?	____	____	____
Are you currently using any drugs, including alcohol or marijuana?	____	____	____
Are you using any drugs that may negatively interact with a controlled substance?	____	____	____
Are you using any drugs that were not prescribed by a practitioner that is treating you?	____	____	____
Have you ever attempted to obtain an early refill of a controlled substance?	____	____	____
Have you ever made a claim that a controlled substance was lost or stolen?	____	____	____
Have you ever been questioned about your pharmacy report or PMP report?	____	____	____
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	____	____	____
Have you ever been accused of inappropriate behavior or intoxication?	____	____	____
Have you ever increased the dose or frequency of meds without telling your provider?	____	____	____
Have you ever had difficulty with stopping the use of a controlled substance?	____	____	____
Have you ever demanded to be prescribed a controlled substance?	____	____	____
Have you ever refused to cooperate with any medical testing or examinations?	____	____	____
Have you ever had a history of substance abuse of any kind?	____	____	____
Has there been any change in your health that might affect your medications?	____	____	____
Have you misused or become addicted to a drug, or failed to comply with instructions?	____	____	____
Are there any other factors that your practitioner should consider before prescribing?	____	____	____

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Parent/Legal Guardian	Parent/Legal Guardian	Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Appointment Policy

No shows and cancellations with less than a1 weekdays' notice are a significant problem for our practice. Many practices overbook on purpose so that no-shows and cancellations wont limit access for other patients as well as cause a financial hardship for the practice.

When it comes to no shows and cancellations, we have three choices:

1. A strict policy; or
2. Overbooking (leading to long wait times at our office); or
3. Charging for no shows

We feel the strict policy is the best fit for our practice and we are proud of our ability to run on time.

In the office

Schedule an appointment by calling (702)588-7373.

Schedule same-day appointments for ill visits. When one of our providers speaks with patient it is determined through triage how soon a patient needs to be seen. Our policy is to see patients with urgent-care needs the same day they call if they call at least 2 hours before we close.

Patients who arrive on time are seen at their appointment time. Patients who will have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your visit.

Call ahead if you are late or unable to make your appointment time. We Will do all that we can to accommodate your appointment and to minimize the need to reschedule your appointment.

Turn off cell phones in the office and examination rooms.

Internal Medicine Specialist and Family Medicine Specialists may dismiss families for violation this policy. Violations include:

1. Not Showing for schedule appointments.
2. Cancelling appointments with less than 1 weekdays' notice (excluding holidays)

Thank you for your cooperation and understanding.

_____ _____

Print Name Date

_____

Signature

MEDICAL RECORDS REQUEST

Please Check Box

C. Dean Milne, D.O. _____
Mark E. McKenzie, M.D. _____
Scott Silver, D.O. _____
James Anthony, D.O. _____

Date: _____

Patients Name: _____
Last Name First Name Middle Initial

Patients Date of Birth: _____/_____/_____

Release the records to the following:

Internal Medicine Specialists & Family Specialists of Las Vegas
2010 Wellness Way #100
Las Vegas, Nevada 89106
Phone Number (702)588-7373 Fax Number (702)588-7748

Release the records from the following:

Organization Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Entire Health Records _____
History & Physical _____
Prescription List _____

EKG _____
Radiology/X-Ray Results _____
Lab Results _____

_____ _____
Patient Signature or Legal Representative Date

_____ _____
If signed by Legal Representative/Relationship Date

IMS of Las Vegas
INTERNAL MEDICINE SPECIALISTS

2010 Wellness Way #100
Las Vegas, NV 89106
(702) 588-7373
Fax (702) 588-7748

I,_____Date of Birth_____,
give written consent to the below person(s), to discuss all my medical information.
This includes picking up copies of my medical records.

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient Signature:_____Date:_____