PROBLEM LIST

Name: _____ D.O. B: _____

Allergies to Medication: **REACTIONS:**	Does **PATIENT HAVE** Advanced Directive: **Y N** If yes, copy must be provided to the office.
Family History: Significant for:	Other Physicians:

Chronic Problems	Date Resolved	Temporary Problems	Date Resolved	Surgeries	Date
				Hospitalizations	Date

TESTS	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**
Cardiac Profile								
Colon/Rectal Exam								
Complete Exam								
Lipid Profile								
Mammogram/Base								
Pap Test								
Prostate/PSA								
Stool Blood								
TB								
MMR								
Tetanus/TD								
Varicella								
Pneumonia/Yearly Flu								
Vision/Glaucoma								
X-Ray/EKG								
Other:								

Tobacco Use: Yes No	**Alcohol Use:** Yes No	**Drug Use:** Yes No
_____Packs/Day _____ Years _____Quit _____ Years	_____Beer _____oz./week _____Wine _____oz./week _____Liquor _____oz./week	Type_____ How often_____ Quit_____ Years _____

Wolfson Medical Center

PATIENT INFORMATION

Patient name: _____ Birth date: _____

Phone: _____

Address: _____ Cell Phone: _____

City, State, Zip code: _____ Social Sec # _____

(If minor please provide parents)

Email address for billing purpose: _____

SEX: [MALE] [FEMALE] **STATUS:** [MARRIED] [SINGLE] [WIDOWED] [OTHER]

Reason for your visit _____

How did you hear about us? _____ Referred by: _____

EMPLOYER INFORMATION

[EMPLOYED] [UNEMPLOYED] [FULL-TIME STUDENT] [RETIRED]

(If minor provide parents)

Employer Name: _____

Employer Address and phone number: _____

_____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Insured Name: _____ Insured Name: _____

ID #: _____ ID #: _____

Relationship to Patient: _____ Relationship to Patient: _____

EMERGENCY INFORMATION

Contact Name: _____ Relationship: _____

Daytime Number: _____ Nighttime number: _____

I hereby guarantee payment for the entire balance of the above-named patient. I assign and authorize payment of medical benefits directly to Wolfson Medical Center and his representatives. I authorize release of any information requested by insurance companies or government agencies about this assignment, I have read, understand, and agree to the financial policies and various releases and guarantees.

Patient Signature: _____ Date: _____

A copy of this paperwork is the same value of its original.

Wolfson Medical Center

MEDICATION INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ALLERGIES: _____

_____

_____

CURRENT MEDICATION

Name	Strength	Frequency	Quantity

Updated by:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PHARMACY YOU WOULD LIKE US TO HAVE ON FILE FOR MEDICATION TO BE CALLED IN.

PHARMACY NAME: _____

PHARMACY PHONE: _____

A copy of this paperwork is the same value of its original.

PLEASE BE ADVISED, WE WILL NO LONGER BE PROVIDING CHRONIC NARCOTIC PAIN MANAGEMENT SERVICES. INFORM US IF THIS IS THE PURPOSE OF YOUR VISIT SO WE MAY REFER YOU TO THE APPROPRIATE PAIN MANAGEMENT SPECIALIST.

Advanced Directives

Adults 18 years and older have the right to make decisions regarding their own health care. They may accept or refuse care based on their own desires. The best time to determine what will be regarding the choice of health care is before admitted to a health care facility. In the event a person loses the ability to make these decisions, there are two legal documents that protect their right to refuse unwanted medical treatment, or to request treatment that is wanted. These documents are called Advanced Directives.

There are two forms of Advanced Directives that are acknowledged in Nevada.

1. Declaration (Living Will) NRS 449.535-449.720

The Declaration (Living Will) is in effect only when the attending physician determines the patient's condition is terminal and there is no chance for recovery. The Declaration (Living Will) allows a person to state his or her own medical decisions.

2. Durable Power of Attorney NRS 449.800-449.860

The Durable Power of Attorney for Health Care allows a person to name someone else to make the decisions about their medical care, including decisions about life support, if they can no longer speak for themselves. This appointed person may make decisions regarding health care if a condition renders the patient unable to speak; it does not require the condition to be terminal.

In the case that a person has not prepared an Advanced Directive, the closest living relative would be asked to give consents and make decisions for the health care given.

For more information regarding Advanced Directives or to ask questions, you may contact the following resources:

Department of Human Resources
Health Divisions
Bureau of Licensure and Certification
4220 South Maryland Parkway, #810
Las Vegas, NV 89119 702 486-6515

Choice in Dying
1620 Eye Street N.W., #202
Washington D.C 20006
1 800-989-9455

Because the Durable Power of Attorney for HealthCare Decisions is legal document, you may want to contact the following for a referral to an attorney.

State Bar of Nevada
600 East Charleston Blvd.
Las Vegas, NV 89104 702 382-2200

State Bar of Nevada
1325 Airmotive Way, #140
Reno, NV 89502 775 329-4104

***Providers of service are required to inform their patients of their right to formulate an Advanced Directive, prior rendering medical treatment that requires a consent form and to document in the enrollee's medical record whether an Advanced Directive has been executed.

I have an Advanced Directive ☐ **Yes** *IF YES, please provide copy to office.* ☐ **No**

Signature: _____ Date: _____

A copy of this paperwork is the same value of its original.

Wolfson Medical Center

☐ 6803 W. Tropicana Ave **☐ 2655 Box Canyon Dr.** **☐ 921 S. Las Vegas Blvd**

Las Vegas NV 89103 **Las Vegas, NV 89128** **Las Vegas, NV 89101**

Phone (702) 452-2525 **(702) 363-9900** **(702) 910-2100**

Fax (702) 452-2534 **(702) 363-9995** **(702) 910-2105**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

☐ STAT PATIENT IN OFFICE NOW

Patient Name: _____

SSN: _____ **Date of Birth: _____/_____/_____**

. . . . . .

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: _____

_____

Please provide contact information for provider. Failure to do so will delay the process in obtaining medical records.

Address: _____

Phone: _____ Fax: _____

TO RELEASE RECORDS TO: _____

Please provide contact information for provider. Failure to do so will delay the process in obtaining medical records.

Address: _____

Phone: _____ Fax: _____

. . . . . .

(Check all applicable): All Records **Laboratory/Pathology Records** **X-Ray/Radiology Records**

Abstract/Summary **Pharmacy Records** **Other: _____**

. . . . . .

Please initial if you wish any of the following not to be released.

Do not release information related to:

_____Substance Abuse **_____Psychiatric/ Mental Health** **_____HIV**

_____Other: _____

. . . . . .

The information may be used/disclosed for the following purpose:

To continue care **For health insurance** **Other: _____**

_____ **_____**

Signature of Patient **Printed Name**

_____

Date

This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time. If records being to patient, there is a charge of .60 cents per page.

A copy of this paperwork is the same value of its original.

MEDICAL HISTORY SHEET

Name: _____Date of Birth: _____

Allergies to medication? [YES] [NO]
If yes, list name of medication and description of reaction_____
_____

CURRENT MEDICAL HISTORY

Patient medical history:

Cancer	Stroke	Thyroid	Emphysema	Asthma
Diabetes	Seizure	Kidney Problems	Aneurysm	Osteoporosis
Anemia	Heart Attacks	Lupus	Rheumatoid Arthritis	High Cholesterol
Hypertension	Heart Failure	Psychiatric Disorder	Neurological Disorder	

SOCIAL HISTORY

Do you currently smoke? [YES] [NO]
If yes, how long? _____, How much? _____

If no, have you ever smoked? [YES] [NO]
If yes, how long? _____, How much? _____

Do you consume alcohol? [YES] [NO] If yes, how many drinks per day? _____

Do you consume **caffeine?** [YES] [NO] COFFEE**?** [YES] [NO] SODA**?** [YES] [NO]

Do you exercise? [YES] [NO] If yes, what type of exercise? _____How often? _____

Occupations: PRESENT _____PAST _____

MEDICAL HISTORY

Surgeries and approximate dates: _____
_____

Hospitalizations (Other than for surgery) _____
_____

HEALTH SCREENING

When did you last have:
- EKG _____
- Chest X-ray _____
- Mammogram _____
- Breast Exam _____
- Rectal Exam _____
- TB Skin Test _____
- Screening cholesterol_____

Immunizations?
- Hepatitis _____
- Diphtheria _____
- Polio _____
- MMR (Measles, Mumps, Rubella) _____
- Pneumonia shot _____
- Flu (influenza) shot _____
- Tetanus _____

A copy of this paperwork is the same value of its original.

For the following, mark whether you have ANY of the following symptoms:

EYES YES NO
Cataracts _____
Pain in eyes _____
Double vision _____
Sudden vision loss _____
Glaucoma _____

EARS
Pain _____
Bleeding _____
Buzzing _____
Dizziness _____
Loss of hearing _____
Earaches _____

NOSE AND THROAT
Hoarseness _____
Pain _____
Bleeding _____
Stuffy nose _____
Trouble swallowing _____

MUSCULOSKETAL
Morning Joint Stiffness _____
Swelling/Arching
Joints _____
Severe backaches _____

NERVOUS SYSTEM
Seizure/Convulsions _____
Fainting Spells _____
Stroke _____
Paralysis/Weakness of
A limb _____
Increasing trouble w/
Memory _____
Getting lost easily _____
Hallucinations _____
Tingling in a limb _____
Numbness in any
Part of the body _____
Shaking of a limb _____
Staggering _____
Migraine Headache _____
Inability to speak _____

CHEST
Pleurisy _____
Coughing of blood _____
Pneumonia _____
Clots on lungs _____
Tuberculosis _____
Wheezing or Asthma _____

HEART YES NO
Aching in mid-chest _____
Skipping beats _____
Shortness of breath _____
Fainting spells _____
Heart murmur _____
Swelling of ankles _____
High blood pressure _____
Of years _____
Heart attack _____
How many? _____
When? _____

GASTROINTESTINAL
Stomach pains/
Indigestion _____
Heart burn _____
Constipation _____
Recent changes
In Bowel habits _____
Vomiting of blood _____
Ulcers _____
Loss of appetite _____
Chronic diarrhea _____
Black, tarry stool _____
Bright, red blood
By rectum _____
Rectal pain _____
Swelling of abdomen _____
Jaundice _____
Tea-colored Urine _____

URINARY
Burning on urination _____
Bloody urine _____
Frequent urination _____
Difficulty in getting
Urination started _____
Backaches _____
Losing urine control W/
Coughing/sneezing _____
Kidney stone _____

HEAD AND NECK
Stiff neck _____
Severe or frequent
Headaches _____

SKIN
Hives _____
Shingles _____
Frequent boils _____
Recurrent itching _____
Ulcers _____

BLOOD YES NO
Anemia _____
Very easy bruising _____
Bleeding disorder _____
Lumps under arms
/groin _____

ENDOCRINE
Thyroid trouble _____
Intolerance to cold/
Heat _____
Diabetes _____
Excessive thirst _____
Loss of sex drive/
Erection ability _____

PSYCHIATRIC
Depression _____
Anxiety attacks _____

BREASTS
Tenderness around
Periods _____
Discharge from
Nipples _____
Blood from nipples _____
Lump in breast _____
Cancer _____

GYNECOLOGICAL
Date of last pap smear _____
Date of last period _____
Date of menopause _____
Bleeding since
Menopause _____
Discharge _____
Excessive bleeding
W/ periods _____
Dilation & curettage
(D&C) _____
Venereal disease _____

OBSTETRICS
Of pregnancies _____
Of live births _____
Of miscarriages _____
Of stillborn _____
Of therapeutic
Abortions _____

Office Policies

PLEASE READ AND SIGN ALL, IT MAY NOT APPLY BUT THESE ARE THE OFFICE POLICIES.

PATIENT RESPONSIBILITY:

It is your responsibility to follow up on any lab or test results (i.e. mammogram, x-ray, blood work, etc.) If you know you obtaining any tests, please make a follow up appointment at the time of check out. If we are waiting for insurance approval, please make an appointment with us after the test has been approved by the insurance company. **I understand that effective April 30, 2014 there will be a $50.00 cancellation fee when scheduled appointments are not cancelled 24 hours prior. To avoid any fees please cancel any appointments 1 business day prior.**

Signature: _____ Date: _____

PATIENT POLICY:

Payment is due in full at the time of service. We do bill most insurance company as courtesy to you, but you are ultimately responsible for all charge incurred if your insurance company should choose not to pay. Deductible, co-pay, and co-insurance are due at the time of service. **WE DO NOT ACCEPT CHECKS, NO EXCEPTIONS!!**

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to, including Medicare, Private Insurance Companies and any other health plan to WMC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether they are paid by insurance company. I hereby authorize said assignee to release all information necessary to secure payment. I understand that my medical insurance carrier may not cover some services and, that I may be responsible for payment of charges.

Signature: _____ Date: _____

RECORDS RELEASE:

I hereby authorize the release of any medical or billing information (including medical records) by Wolfson Medical Center to my referring doctor, insurance company, or responsible party.

Signature: _____ Date: _____

MEDICATION ADMINISTRATION:

I am aware that the medical assistants administer the injections, medication, nebulizer treatments, and TB skin tests.

Signature: _____ Date: _____

TO ALL SUBOXONE PATIENTS:

THE SUBOXONE TREATMENT will not be billed to any insurance. The office visit must be paid in full at time of service. Any re-imbursement from insurance will not be accepted.

Signature: _____ Date: _____

A copy of this paperwork is the same value of its original.

Acknowledgement of receipt of privacy practice

Patient Name: _____ Date of birth: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional.

Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from WMC. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of federal Regulations.

Patient Record of Disclosures

I wish to be contacted in the following manner (Check all that applies).

□ Home Telephone: _____

□ OK to leave a detailed message □ Leave message with only call back number

□Work Telephone: _____

□ OK to leave a detailed message □ Leave message with only call back number

□Written Communication:

□OK to mail to home address □ OK to fax to _____

Record of disclosures of protected health information

NAME	RELATIONSHIP	PHONE #

Patient Signature: _____ Date: _____

PLEASE NOTE: Uses and disclosures for TPO (Treatment/Payment/Healthcare Operations) may be permitted without prior Consent in the case of an emergency.

A copy of this paperwork is the same value of its original.

Controlled Substances Agreement

PLEASE BE ADVISED, WE WILL NO LONGER BE PROVIDING CHRONIC NARCOTIC PAIN MANAGEMENT SERVICES. INFORM US IF THIS IS THE PURPOSE OF YOUR VISIT SO WE MAY REFER YOU TO THE APPROPRIATE PAIN MANAGEMENT SPECIALIST.

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term/ short term use of such substances as opioids (narcotic analgesics), benzodiazepine, tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit.

There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged.

For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

2. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

3. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

4. You may not share, sell, or otherwise permit others to have access to these medications.

5. Unannounced, random urine or serum toxicology screens may be requested, this will be at the patient's expense and your cooperation is required. Presence of unauthorized substances may be subject to discontinuation of medication and/or termination from care effective immediately.

6. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

7. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

8. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

9. Early refills will generally not be given.

10. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

11. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

12. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

13. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all its terms.

_____ _____ _____

Patient Name (Printed) Patient Signature Date

Approved by the AAPM Executive Committee on April 2, 2001.

A copy of this paperwork is the same value of its original.

Consent for Suboxone / Subutex Therapy

Suboxone is used to treat opiate addiction.
Subutex is a prescription medication that's used to treat narcotic addictions and dependence.

This decision was made because my condition is serious or other treatments have not helped my pain. I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself.

I am aware that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(**Males only**) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(**Females Only**) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I understand I am expected to follow up with Dr. Wolfson until treatment is complete. Monthly office contact must be made either in person or over the phone to justify continuation in treatment.

If I do not follow up within 30 days after my last office visit it will be assumed, I have successfully completed the treatment. Wolfson medical center will not accept a returning Suboxone patient if he/she does not follow up within the 30-day period allowed. I am aware I will be randomly drug tested at patient's expense. NO EXCEPTIONS!!

I have read this form or have it read to me. I understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient signature: _____ Date: _____

Approved by the AAPM Executive Committee on January 14, 1999.

A copy of this paperwork is the same value of its original.