IMS
INTERNAL MEDICINE SPECIALISTS

201 North Buffalo Drive
Las Vegas NV 89145
T: (702) 242-2737
F: (702) 255-3170
www.IMSDoctors.com

PATIENT INFORMATION:

REFERRING DOCTOR: _____

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

DATE OF BIRTH: _____ **GENDER:** ☐ Male ☐ Female **SSN:** _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

ADDRESS: _____ **APT/SUITE:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PH: _____ **CELL PH:** _____

EMAIL: _____

PREFERRED METHOD OF COMMUNICATION:

☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Other: _____

OK TO LEAVE MESSAGE ON HOME PHONE?
☐ Yes ☐ No

OK TO LEAVE MESSAGE ON CELL PHONE?
☐ Yes ☐ No

EMPLOYER: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMERGENCY CONTACT:

NAME: _____ **RELATION:** _____

PHONE: _____ **EMAIL:** _____

GUARANTOR INFORMATION:

If the primary insurance is through the parent/spouse, please complete this using their information.

NAME OF RESPONSIBLE PARTY: _____

DATE OF BIRTH: _____ **SSN:** _____

RELATIONSHIP: ☐ **Dependent** ☐ **Spouse** ☐ **Other:** _____

EMPLOYER: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____	**SECONDARY INSURANCE:** _____
MEMBER ID: _____	**MEMBER ID:** _____
GROUP NUMBER: _____	**GROUP NUMBER:** _____
GROUP NAME: _____	**GROUP NAME:** _____
CO-PAY: _____	**CO-PAY:** _____
SUBSCRIBER'S NAME: _____	**SUBSCRIBER'S NAME:** _____
SUBSCRIBER'S DOB: _____	**SUBSCRIBER'S DOB:** _____

HOW DID YOU HEAR ABOUT US? _____

☐ **FRIEND: Who shall we thank?** _____

☐ **DOCTOR: Who shall we thank?** _____

☐ **HOSPITAL** ☐ **ADVERTISEMENT** ☐ **WEBSITE** ☐ **ZOCDOC** ☐ **Other:** _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I authorize the release of medical and/or other information as necessary to process health insurance claims. I also request payment of benefits to my Provider when he/she accepts the assignment.

_____ _____

SIGNATURE **DATE**

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MEDICAL HISTORY

PATIENT'S NAME: _____ **DATE:** _____

DOB: _____ **AGE:** _____ **GENDER:** ☐ **Male** ☐ **Female** **SSN:** _____

ALLERGIES

NAME OF DRUG OR TYPE OF ALLERGY	REACTION

CURRENT MEDICATION(S)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

MEDICAL HISTORY

Please indicate whether you have ever had any of the following . . .

YES	NO	CONDITION	YES	NO	CONDITION
☐	☐	High Blood Pressure	☐	☐	Asthma
☐	☐	Heart Attack / MI	☐	☐	Kidney Stone
☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Stomach Ulcer	☐	☐	Pneumonia
☐	☐	Gout	☐	☐	Arthritis
☐	☐	Liver Disease / Hepatitis	☐	☐	Gallbladder Disease
☐	☐	Thyroid Disease	☐	☐	Increased Cholesterol
☐	☐	Psoriasis	☐	☐	Heart Murmur
☐	☐	Cancer	☐	☐	Anemia
☐	☐	Stroke	☐	☐	Blood Transfusion
☐	☐	Accident / Broken Bone(s) _____			
☐	☐	Other (not listed) _____			

HOSPITALIZATION / SURGERY

YEAR	HOSPITAL / CITY	REASON	PHYSICIAN

FEMALES ONLY Are you currently pregnant? ☐ YES ☐ NO Could you possibly be pregnant? ☐ YES ☐ NO

Date of Last Menstrual Period: _____

FAMILY HISTORY

YES	NO	CONDITION	RELATIONSHIP	
☐	☐	Heart Disease	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Diabetes	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Stroke	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Asthma	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Epilepsy	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Bleeding Disorder	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Thyroid Disease	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Cancer	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	High Blood Pressure	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	High Cholesterol	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____
☐	☐	Other:	☐ Father ☐ Mother ☐ Sibling ☐ Other:	_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

HABITS

Do you now or have you ever smoked?	☐ YES	☐ NO	cigarettes/day	_____	Since when?	_____
Do you drink alcohol?	☐ YES	☐ NO	glasses/week	_____	Since when?	_____
Do you use recreational drugs, e.g. marijuana?	☐ YES	☐ NO	frequency	_____	Since when?	_____

REVIEW OF SYSTEMS

Please check any problems that apply to you at this time

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Weakness

LUNGS
- ☐ Cough
- ☐ Coughing With Blood
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Wheezing

ENDOCRINE
- ☐ Coarse Hair
- ☐ Cold/Heat Intolerance
- ☐ Dry Skin
- ☐ Early Menstrual Flow

CARDIOVASCULAR
- ☐ Chest Pain/Tightness
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Passing Out

GYNECOLOGICAL
- ☐ Last Menstrual Period
- ☐ Vaginal Bleeding
- ☐ Vaginal Dryness

GASTROINTESTINAL
- ☐ Black Stool
- ☐ Blood in Stool
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting of Blood
- ☐ Yellow Jaundice

GENITOURINARY
- ☐ Blood In Urine
- ☐ Difficulty/Burning
- ☐ Incontinence (urinary)
- ☐ Penile Discharge
- ☐ Prostate Issue

DERMATOLOGICAL
- ☐ Acne
- ☐ Mole(s)
- ☐ Skin Itching
- ☐ Skin Rash

NEUROLOGICAL
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Weakness
  - ☐ Right:
  - ☐ Left:

EYES
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Drainage
- ☐ Eye Exam (abnormal)
- ☐ Eye Redness

H E N T
- ☐ Change in Voice
- ☐ Decreased Hearing
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Headache
- ☐ Hoarseness of Voice
- ☐ Throat Pain

MUSCLES / JOINTS
- ☐ Joint Swelling/Pain
- ☐ Muscle Stiffness
- ☐ Muscle Spasm

SCREENING PROCEDURE(S)

Last EKG	**DATE:**		**Last Chest Xray . . . . . .**	**DATE:**	
Last Treadmill	**DATE:**		**Last Blood Work . . . . . .**	**DATE:**	
Last Sigmoid/Colonoscopy .	**DATE:**		**Last Dexascan . . . . . .**	**DATE:**	

FEMALES ONLY

Last Pap Smear	**DATE:**		**Last Mammogram . . . . . .**	**DATE:**	

I certify that the above information is true to the best of my knowledge.

PATIENT'S NAME: _____

_____ _____

PATIENT'S SIGNATURE **DATE**

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PHARMACY INFORMATION

PHARMACY 1: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MAJOR CROSS STREETS: _____

PHARMACY 2: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MAJOR CROSS STREETS: _____

PHARMACY 3: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MAJOR CROSS STREETS: _____

PATIENT'S NAME: _____

_____ _____

PATIENT'S SIGNATURE **DATE**

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INSURANCE AND FINANCIAL RESPONSIBILITY

We are thankful you have chosen our practice for your healthcare needs. Please be aware that medical insurance is a contract between you and your insurance carrier. You are ultimately responsible for payment of our services.

YOUR CO-PAY / MEDICAL DEDUCTIBLE / CO-INSURANCE AMOUNT IS DUE AND PAYABLE AT THE TIME OF YOUR VISIT.

We are happy to bill your insurance if we are a provider on your plan. To ensure no interruption in care,

- **Please understand that your co-pay, deductible, and or co-insurance amount(s) and be prepared to pay at the time of visit**
- **Check with your insurance if authorization is required for any testing**
- **Find out which diagnostic facilities are in-network with your insurance plan**

I have read and understood that billing my insurance is provided as a courtesy and is not a guarantee of payment. I am ultimately responsible for payment of my medical bill(s).

PATIENT'S NAME: _____

_____ _____
PATIENT'S SIGNATURE **DATE**

AUTHORIZED REPRESENTATIVE'S NAME: _____

_____ _____
AUTHORIZED REPRESENTATIVE'S SIGNATURE **DATE**

RELATIONSHIP TO PATIENT: _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, hereby give permission to Internal Medicine Specialists to release my information to the following:

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

I fully understand that I can revoke this authorization at any time.

PATIENT'S NAME: _____

_____ _____

PATIENT'S SIGNATURE **DATE**

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

There will be a service fee of $0.60 per page for medical records forwarded to a lawyer, insurance company, or directly to the patient. We will, however, transfer medical records to another physician at no cost.

I hereby authorize my Provider to release any information necessary for the course of treatment.

TODAY'S DATE: _____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

RELEASE THE FOLLOWING RECORDS TO:

INTERNAL MEDICINE SPECIALISTS
201 N Buffalo Dr Las Vegas NV 89145
TEL (702) 242-2737 ● FAX (702) 255-3170

RELEASE THE FOLLOWING RECORDS FROM:

ORGANIZATION'S NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: _____ **FAX:** _____

- ☐ **Entire Health Record**
- ☐ **History and Physical**
- ☐ **Prescription List**
- ☐ **Laboratory/Radiology Result (s)**
- ☐ **Blood Sugar Result (s)**
- ☐ **EKG**

_____ _____
PATIENT'S SIGNATURE **DATE**

_____ _____
AUTHORIZED REPRESENTATIVE'S SIGNATURE **DATE**

RELATIONSHIP TO PATIENT: _____

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ADVANCED CARE PLANNING

Advance Directives
PATIENTS 18 YEARS OR OLDER

Advance care planning is making decisions about the healthcare you would want to receive if you're facing a medical crisis. These are your decisions to make based on your personal values, preferences, and discussions with your loved ones.

- **Advance care planning includes:**
  Getting information on the types of life-sustaining treatments that are available.
- **Deciding what types of treatment you would or would not want should you be diagnosed with a life-limiting illness.**
- **Sharing your personal values with your loved ones.**
- **Completing advance directives to put into writing what types of treatment you would or would not want – and who you chose to speak for you – should you be unable to speak for yourself.**

The term advance directive describes legal documents that enable you to plan for and communicate your end-of-life wishes in the event that you are unable to communicate, a living will and healthcare power of attorney. This section will describe advance directives, choosing and being a healthcare agent and preparing your advance directives.

Decisions about end-of-life care are deeply personal and are based on your values and beliefs. Talking with your loved ones, your healthcare providers, and even your friends are all important steps to make your wishes known. These conversations will relieve loved ones and healthcare providers of the need to guess what you would want if you are ever facing a healthcare or medical crisis.

Please check one of the statements that apply to you:

☐ **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 place. I have read and understood the information above on Advance Directives.**

PATIENT'S NAME: _____

_____ _____

PATIENT'S SIGNATURE **DATE**

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BA USED AN DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that related to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Informational Uses and Disclosures of Protected Health Informational. Your protected health information may be used and disclosed by your physician, our office staff and other outside out office that are involved in your care and treatment for the purposes of providing healthcare services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have ben referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated by this authorization.

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 do not 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 not be disclosed to family members or friends that my 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.

You physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest 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.

You 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, e.g., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You 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 your for filing a complaint.

This notice was published and become effected on or before April 14, 2003.

We are required by law to maintain the 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 Office Administrator/HIPAA Compliance Officer in person or by phone at (702) 242-2737.

By signing below, you are acknowledging you have received this Notice of Privacy Practices.

PATIENT'S NAME: _____

_____ _____

PATIENT'S SIGNATURE **DATE**