

CARDIOVASCULAR

SURGERY

OF

SOUTHERN

NEVADA

Dear Patient:

Welcome to Cardiovascular Surgery of Southern Nevada. You have previously been scheduled to visit one of our physicians in our office, which is located at 5320 S. Rainbow Blvd, Suite 282, Las Vegas, Nevada 89118. If you are unsure of your appointment time and date, please contact our office by phone at (702) 737-3808.

In an effort to expedite the time you will spend in our office we are enclosing forms for your completion prior to your scheduled appointment. Please take the time to complete the forms at your convenience and bring the completed forms along when you come to our office.

The following items will be needed for your initial appointment:

1. Patient Information Sheet and Authorization to Release Medical Records sheet (*fully completed*)
2. Health History and Physical Exam Form (*fully completed*). If there is not enough room on the form, please attach a separate list of medications (include dosage amount and frequency), surgical history, and allergies.
3. Financial Responsibility Acknowledgement
4. All insurance cards (*primary and all secondary coverages*)
5. Picture identification card
6. Films (x-ray, CD or VHS tape)

**All items above will be needed the day of your appointment. However, it is imperative your films arrive at our office the day before your appointment to ensure they are the correct films. Films are necessary to evaluate the need for surgery; the written report alone is not sufficient. If we do not have the correct films, your appointment will be rescheduled to the next available date. If you need help in locating your films please call Yvonne in our office at least 2 days before your appointment so we can assist you.**

If you have questions otherwise about the forms or about your scheduled appointment, please call Yvonne at 737-3808 ext. 137. Also, please call if for any reason you are unable to keep your scheduled appointment.

Thank you,

The Staff at Cardiovascular Surgery of Southern Nevada

V.C. Smith, M.D., F.A.C.S.

Nancy A. Donahoe, M.D., F.A.C.S.

J.E. "Rick" Martin, Jr., M.D., F.A.C.S.

Demetri Mavroidis, M.D.

Neel V. Dhudshia, M.D.

Harry W. Donias, M.D.

5320 S. Rainbow Blvd

Suite 282

Las Vegas, NV 89118

(702) 737-3808

(800) 200-2128

Fax: (702) 737-7364

www.cvsurgnv.com

Cardiovascular Surgery of Southern Nevada  
5320 S. Rainbow Blvd, Suite 282  
Las Vegas, Nevada 89118  
(702) 737-3808

Dear Patient,

In an effort to avoid confusion and duplication of records, we ask that you fill out the attached information sheets with your full legal name. If you use a different name than the one on your insurance card, please inform us. Also, if your legal name is hyphenated, please use it each time you contact our office.

Thank you.

The Staff of Cardiovascular Surgery of Southern Nevada

**CARDIOVASCULAR SURGERY OF SOUTHERN NEVADA**  
**PATIENT INFORMATION**  
PLEASE PRINT

*Welcome to Our Office*

Patient's Last Name		Suffix	Home Phone
First Name		Middle initial	Alternative Phone
Street Address		Apt #	Date of Birth
City	State		Social Security #
Zip	Sex		Primary Care Doctor Phone #
Marital Status	Employed		Primary Care Doctor Name

Patient's Employer		Occupation (indicate if student)	How long employed?	Business Phone #
Employer's Street Address		City	State	Zip Code
Spouse or Parent's Name		Social Security #	Date of Birth	
Spouse or Parent's Employer		Occupation (indicate if student)	How long employed?	Business phone #
Employer's Street Address		City	State	Zip Code

Emergency Contact's Name		Relationship	Home phone #	
Emergency Contact's Street Address		City	State	Zip Code

Referring Physician Name			Referring Physician Phone #			
Primary Insurance		Street Address		City	State	Zip
Insurance Phone #		Effective Date		ID#		
Insured Name		Relationship		Group #		
Secondary Insurance		Street Address		City	State	Zip
Insurance Phone #		Effective Date		ID#		
Insured Name		Relationship		Group #		

Please circle one:

**Workers Compensation ?    Yes    No    Motor Vehicle Accident ?    Yes    No**

I authorize the release of protected health information for the purpose of treatment, payment, and health care operations. I authorize fax transmission of medical records, if necessary. I authorize payment of insurance benefits, both basic and major medical, to Cardiovascular Surgery of Southern Nevada. I have read and understand the financial policy of Cardiovascular Surgery of Southern Nevada. The HIPAA Privacy Notice for Cardiovascular Surgery of Southern Nevada has been made available to me.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

# Cardiovascular Surgery of Southern Nevada

## History & Physical

(Confidential)

Patient Identification
------------------------

Name \_\_\_\_\_  
 Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Reason for Visit / Chief Complaint \_\_\_\_\_

Today's Date \_\_\_\_\_  
 Date of last physical examination \_\_\_\_\_

### PAST MEDICAL/SURGICAL HISTORY

**Do you have or have had: (please check all that apply)**

<b>General</b> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<b>Gastrointestinal</b> <input type="checkbox"/> Appetite Poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood	<b>Eye, Ear, Nose, Throat</b> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos <input type="checkbox"/> Double Vision <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus Problems	<b>Men only</b> <input type="checkbox"/> Breast Lump <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump in Testicles <input type="checkbox"/> Penis Discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other _____  <b>Muscle/Joint/Bone</b> Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Back <input type="checkbox"/> Feet <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders	<b>Women only</b> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Extreme Menstrual Pain <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Other _____  <b>Respiratory</b> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing
---	--	--	---	--

**Cardiovascular**  
 Chest Pain  
 Congestive Heart Failure  
 High Blood Pressure  
 Irregular Heart Beat  
 Low Blood Pressure  
 Poor Circulation  
 Rapid Heart Beat  
 Swelling of Ankles  
 Varicose Veins

**Genito-Urinary**  
 Blood in Urine  
 Frequent Urination  
 Lack of Bladder Control  
 Painful Urination

**Skin**  
 Bruise Easily  
 Hives  
 Itching  
 Change in Moles  
 Rash  
 Scars  
 Sore that won't heal

**Conditions (please check any you have or had in the past)**

<input type="checkbox"/> AIDS <input type="checkbox"/> HIV Positive <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other _____
--	---	--	---	--

**Medications & Dose**


**Allergies (Medications & Other)**

**Have you ever had a blood transfusion?**     **Yes**                       **No**

If yes, please give approximate dates: \_\_\_\_\_

**Family History (include diabetes, hypertension, stroke, aneurysm, varicose veins, amputation)**

Relation	Current Age/Serious Illnesses	Age at Death/Cause of Death
Father		
Mother		
Brothers		
Sisters		

**Surgery/Hospitalization/Serious Illness**

Year	Illness/Procedure	Complications

**Social History (please check and indicate usage)**

 Caffeine \_\_\_\_\_  
 Tobacco \_\_\_\_\_  
 Drugs \_\_\_\_\_  
 Alcohol \_\_\_\_\_  
 Other \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_



V.C. Smith, M.D.  
 J.E. Martin, Jr. M.D.  
 Neel V. Dhudshia, M.D.

Nancy A. Donahoe, M.D.  
 Demetri Mavroidis, M.D.  
 Harry W. Donias, M.D.

<b>PATIENT'S LIST OF PHYSICIANS</b>
-------------------------------------

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Date Completed: \_\_\_\_\_

SPECIALTY	PHYSICIAN NAME	ADDRESS	PHONE
Primary Care			
Cardiologist			
Nephrologist			
Pulmonologist			
Other Physicians			

**CARDIOVASCULAR SURGERY OF SOUTHERN NEVADA**

**Authorization to Release Medical Records**

*(Please read carefully.)*

Since HIPAA legislation became effective in April of 2003, we are no longer allowed to automatically assume that our patients authorize us to give out information about their care to anyone other than themselves: not even to immediate family members or close friends. For that reason, please list the names of all family members, friends, organizations, etc. that you give us permission to release information to about your care. If anyone not listed on this form calls or otherwise asks us for information about you (even for information as basic as when your next appointment is or how you are doing in surgical follow up), we will have to refuse to give them that information until we get your expressed permission to do so. Please do not list here your primary care doctor, the doctor who referred you to us, or your medical insurance(s), as these people automatically have access to your information kept at this office.

The following persons are allowed to have information about my care at CSSN:  
(Please list all that apply.)

---

(Name) (Relationship) (Phone#)

---

(Name) (Relationship) (Phone#)

---

(Name) (Relationship) (Phone#)

---

(Name) (Relationship) (Phone#)

---

(Name) (Relationship) (Phone#)

---

(Name) (Relationship) (Phone#)

---

(Name) (Relationship) (Phone#)

---

Patient Name (print)

---

Patient or Guardian signature

---

Date

**CARDIOVASCULAR SURGERY OF SOUTHERN NEVADA**

5320 S. Rainbow Blvd, Suite 282

Las Vegas, Nevada 89118

(702) 737-3808

**NOTICE REGARDING SURGICAL CARE**

The physicians of Cardiovascular Surgery of Southern Nevada provide care for cardiac, vascular and thoracic surgery only. Our scope of practice does not include providing care for any other medical specialty. For that reason we want to make it clear you are aware, the services provided at CSSN will only be for care provided by our specialty.

It is extremely important that you follow up with your primary care, family doctor, internal medicine physician or other specialists you may see for continued care and to follow other medical conditions you may have.

Our office will not provide prescriptions for anything other than the surgery we perform. In addition we do not complete handicap applications, FMLA forms or disability forms. If you take medications for any medical condition be sure and follow up with your primary care, family doctor, internal medicine physician or other specialists to refill those medications. This office will only refill medications related to the surgery we perform.

Should you have questions regarding this notice, please feel free to discuss them with your physician and/or medical assistant at the time you see the doctor.

\_\_\_\_\_  
Patient name (printed)

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

# **CARDIOVASCULAR SURGERY OF SOUTHERN NEVADA**



## **PRESCRIPTION REFILL GUIDELINES**

If you need to have a prescription refilled that our physicians have written previously, please call your pharmacy and they will contact us directly.

**PHARMACY FAXES ARE ADDRESSED WITHIN 48 HOURS, UNLESS WE RECEIVE THE FAX ON A FRIDAY AFTERNOON IN WHICH CASE IT WILL BE ADDRESSED ON MONDAY.**

Please make sure you allow ample time in the event you are running low on a prescription. The fax number for the pharmacy refill request is (702) 737-0154. If you are in need of a written prescription, call (702) 737-3808 option 4 and leave a message with your doctor's medical assistant.

**PLEASE ALLOW 72 HOURS FOR YOUR WRITTEN PRESCRIPTIONS TO BE READY.**

Thank you in advance for your cooperation.

**5320 S. RAINBOW BLVD, SUITE 282, LAS VEGAS, NV 89118**

**Phone (702) 737-3808 option 4**

**Fax (702) 737-0154**

# CARDIOVASCULAR SURGERY OF SOUTHERN NEVADA

## FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing the physicians at Cardiovascular Surgery of Southern Nevada as your health care provider. We appreciate the opportunity to provide you with professional cardiovascular care.

The following is our financial policy. We believe having financial matters clear from the onset is preferable to encountering difficulties later on. If you have any questions or concerns about our payment policies, please do not hesitate to ask our Billing Department and/or Administrator.

Payment for services is due at the time service is rendered. We accept cash, checks and for your convenience MasterCard and Visa. We will submit an insurance claim on your behalf if we have a provider agreement with your insurance company. If we do not have a provider agreement with your insurance company we will submit an insurance claim on your behalf if you provide our office with accurate insurance billing information.

You must understand the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles, co-insurance and co-payments are due at the time of treatment. You are responsible for knowing these amounts.
3. You are responsible for knowing your insurance benefits. We will do our best to assist, however you should know if your insurance requires a primary physician (PCP) referral; if our physicians participate in your plan and what facilities (hospitals, lab, imaging, etc.) your plan requires you to go for services.
4. If you have inadequate or no insurance coverage, advance planning for payment before surgery will be required. The fee for surgery will normally include your post operative office visits up to a period of 45 to 90 days depending on your insurance.
5. Patient balances over 60 days old will be subject to interest charges.
6. You are responsible for any and all collection fees, legal fees and court costs associated with efforts to collect payment on your account.
7. If your insurance carrier changes our Billing Department must be notified immediately
8. It is the policy of this office that patients be charged \$30 per missed appointment when 24 hours advance notice is not provided for cancellation.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems with our Billing Department so that we can assist you in the management of your account.

---

Print Patient Name

---

Date

---

Patient or Guardian Signature

7.24.2009