Innovative Procedural and Surgical Center

9920 West Cheyenne Ave., Ste. 120, Las Vegas, NV 89129
(Next to the Las Vegas Metropolitan Police Academy)

P: (702) 998-7179
F: (702) 405-7676
PainFreeNevada.com

After your initial visit to the Innovative Procedural and Surgical Center these forms must be completed at every visit. Please refer to the following list.

1. Registration Form: Needs to be completed if there are any changes or updates to your information such as address, phone number or insurance or if you have not been seen within the current year at IPSC.

2. Email Address/Driver: Please complete this form to receive our satisfaction survey via email regarding your care at the surgery center. If you do not provide us with this information, then a hard copy of the survey can be mailed out to you at your request. It is very important to have a driver at every visit. The driver does not need to stay during the procedure, but we will need contact information prior to procedure.

3. Pre-Anesthesia Record: (Must be completed every 30 days.)

- Please complete this form the day before your scheduled procedure.
- If you have been into the surgery center in the last 30 days then you do not need to complete the form.
- The pre-op nurse will review your previous form with you for any updates.

4. Patient Home Medication List: (Must be completed at every visit.)

- Please complete this form the day before your scheduled procedure.
- The date and time of each medication last taken must include any medications taken the morning of the procedure.
- If you usually take any blood pressure and/or seizure medications and/or thyroid medications in the morning, please take them in the morning with a sip of water. Do not take any other medications.
- Please verify with your physician the time period you are to withhold taking any anti-coagulant medications such as: Aspirin, Plavix, Coumadin, Ibuprofen/Motrin, Advil, and Pradaxa.

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Innovative Procedural and Surgical Center is committed to providing the highest level of patient care. To achieve this objective, we ask our patients or their caretaker to complete a brief patient satisfaction survey after their visit.

To better serve you we have automated this process. Within 72 hours, you will receive an email providing you with a link to complete our survey. The survey is performed online via a secure internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback.

Please write legibly and provide the email address to forward the survey to in the boxes below:

Please check here ☐ If you do not have email, please let us know and we will provide you with a paper version of the survey to complete and return to us.

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

You will need a driver after your procedure to drive you home.
Please provide the information below, even if your driver plans on staying in the waiting area.

Driver's Name ______________________________

Relationship to Patient ______________________________

Telephone Number for Driver ______________________________

Secondary Number ______________________________

☐ My driver will stay in waiting area during my procedure.

☐ Please call my driver when I am about ready to be picked up.

☐ My driver may leave the facility, please call them if they are not in waiting area.

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REGISTRATION FORM

Referring Physician ______________________________

Last Name ______________________ First name ______________________ Middle Initial ____________

Street Address ____________________ City ______________ State ______________ Zip ____________

DOB ____________ Age ________ SSN ____________ Primary Care Physician ______________________

Home Phone ________________ Cell Phone ________________ Email ____________________________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYMENT INFORMATION

Employer ___________________________________ Address ___________________________________

City ______________ State ______________ Zip ____________ Phone # __________________________

Occupation ___________________________ Other: ☐ Not employed ☐ Retired ☐ Disabled ☐ Student

INSURANCE INFORMATION

Primary Insurance ____ Start Date ____________________

Member / Policy # ___________________________ Group Name / Number __________________________

Policyholder's Name _________________________ SSN ___________________ DOB ________________

Policyholder's Employer _____________________ Relation to patient: ☐ Self ☐ Spouse ☐ __________

Secondary Insurance _______________________________________ Start Date ____________________

Member / Policy # ___________________________ Group Name / Number __________________________

Policyholder's Name _________________________ SSN ___________________ DOB ________________

Policyholder's Employer _____________________ Relation to patient: ☐ Self ☐ Spouse ☐ __________

ATTORNEY INFORMATION

Law Firm ____ Attorney _____________________________

Address ____

Phone Number __________________ Fax _________________ Email _____________________________

Start Date _________________________________ Date of Injury (DOI) _____________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact ______________________________________ Phone __________________________

Relation to Patient: ☐ Spouse ☐ Parent ☐ Caregiver ☐ Sibling ☐ Child ☐ ____________________

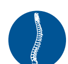
WE HAVE VISUAL, AUDITORY, INTERPRETIVE (LANGUAGE AND AMERICAN SIGN LANGUAGE) SERVICES AVAILABLE TO YOU FREE OF CHARGE

****DO YOU REQUIRE ANY SPECIAL ASSISTANCE? ☐ YES ______________________ ☐ NO**

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Innovative Procedural & Surgical Center medical benefits, if any, from my insurance carrier that would otherwise be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the surgery center to release all information necessary to secure the payment of benefits and/or further medical treatments. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient or Responsible Party Signature _________________________________ **Date** ________________



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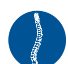
PRE-ANESTHESIA RECORD **ALLERGIES:** ______________________ **HEIGHT:** ________ **WEIGHT:** ________ **LBS**

	Y	N		Y	N
1. Have you or your family member had a high fever or unexplained fever during / after surgery? Explain:___________	☐	☐	**Do you have or have you had: If " yes " please describe.**		
2. Have you or your family ever had a complication from anesthesia? Explain: ___________	☐	☐	26. Diabetes: ☐ Insulin ☐ Oral meds ☐ Diet	☐	☐
3. Do you have a rubber or latex allergy or sensitivity?	☐	☐	27. Heart Disease: (Mitral Valve Prolapse, Heart Attack, Angina, Palpitations)	☐	☐
4. Do you have sleep apnea? If yes, do you use c-pap or bi-pap? ___________	☐	☐	28. Hepatitis: If yes, Type ☐ A ☐ B ☐ C	☐	☐
5. Do you snore?	☐	☐	29. Hypertension (High Blood Pressure)	☐	☐
6. Has anyone said you stop breathing for periods while you sleep?	☐	☐	30. Pacemaker / Defibrillator	☐	☐
7. Do you drink alcohol ? How often ___________ Last Drink ___________	☐	☐	31. Asthma ? Last Attack ___________	☐	☐
8. Do you smoke? How many cigarettes a day ________	☐	☐	32. Lung Disease	☐	☐
9. Are you pregnant or could you be ?	☐	☐	33. Cancer, What type ___________	☐	☐
10. Date of last menstrual period ___________	☐	☐	34. Kidney Disease, On dialysis ?	☐	☐
11. Taking any blood thinners ? (Aspirin, Plavix, Coumadin) If yes, last taken when ___________	☐	☐	35. Bleeding / clotting problems ? Blood transfusion?	☐	☐
12. Taking any anti-inflammatories ? (Ibuprofen, Celebrex) If yes, last taken when ___________	☐	☐	36. Thyroid Disease	☐	☐
13. Have you had an abnormal EKG?	☐	☐	37. Seizures or epilepsy	☐	☐
14. Have you had an abnormal Chest x-ray?	☐	☐	38. Stroke	☐	☐
15. Any recent weight change? (significant amount)	☐	☐	39. Back or neck problems	☐	☐
16. Do you have or wear: (Please Check) ☐ Dentures ☐ Partials ☐ Caps ☐ Contact Lenses	☐	☐	40. Severe Headaches	☐	☐
17. Do you have any body piercing ?	☐	☐	41. Frequent Heartburn	☐	☐
18. On oxygen at home ? How many liters ________	☐	☐	42. Broken facial bones	☐	☐
19. Any shortness of breath ?	☐	☐	43. Glaucoma	☐	☐
20. Do you have any metal implants ?	☐	☐	44. AIDS or HIV Positive	☐	☐
21. Do you have arthritis ?	☐	☐	45. Staph Infection (MRSA)	☐	☐
INITIAL VISIT			46. Vancomycin Resistant Enterococcus (VRE)	☐	☐
PATIENT SIGNATURE:			47. Tuberculosis or any of these symptoms: ☐ Night Sweats ☐ Coughing up blood ☐ Cough ☐ Unexplained weight loss	☐	☐
DATE/TIME:					
REVIEWED BY PRE - OP RN SIGNATURE:			**Please list your previous surgeries and dates**		
SECOND VISIT: Return within 30 days. No changes.					
Verified By: ☐ **Patient** ☐ **Pre-op Nurse**					
THIRD VISIT: Return within 30 days. No changes.					
Verified By: ☐ **Patient** ☐ **Pre-op Nurse**					



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MEDICATIONS MUST BE WRITTEN DOWN ON THE

MEDICATION LIST FORM ALONG WITH THE

DATE AND TIME MEDICATIONS WERE LAST TAKEN.

THANK YOU

Innovative Procedural and Surgical Center

PATIENT HOME MEDICATION LIST*

*Home medication list as provided by the patient

Include all medications you have been on in the last 90 days: prescriptions, over the counter, herbals, vitamins, birth control, and/or patches

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ALLERGIES:	You may resume taking all medications as prescribed, except for blood thinning medications/ anticoagulants (Aspirin, Plavix, Coumadin etc.) which you can begin taking again the day after your procedure or as instructed by your doctor.

Name of Medication	Dosage	Frequency	Reason	Last Taken (Date & Time)	Last Taken (Date & Time)	Last Taken (Date & Time)

**** Please contact your prescribing physician for any questions regarding your medications ****

Reviewing Pre-Op RN Signature | **Copy Given to Patient Reviewed with PACU RN** | **Date**

Reviewing Pre-Op RN Signature | **Copy Given to Patient Reviewed with PACU RN** | **Date**

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