CENTENNIAL MEDICAL GROUP

David Lanzkowsky, M. D. -- Alain Coppel, M. D. -- Christopher Curtis, PA-C – James Boesiger, PA-C
4454 N. Decatur Blvd. Las Vegas, Nevada 89130
6030 S. Rainbow Blvd. Bldg. D Ste. B, Las Vegas, Nevada 89118
4640 W. Craig Road, Las Vegas, Nevada 89032
2637 W. Horizon Ridge Parkway, Ste. 110, Henderson, Nevada 89052
Main Office: (702) 839-1203 Main Fax: (702) 839-1301

Welcome to Centennial Medical Group! We are pleased you have chosen our organization to assist you with your interventional pain needs. ***Our goal is to make every visit pleasant.*** We know your time is valuable. We will work with you to keep appointments on schedule and to ensure adequate time with your physician/practitioner. To do this, we need your help!

Please read this entire package carefully.

All requested information must be completed so we can best serve your needs. Completion and return of this information prior to your scheduled appointment helps us verify and collect key information in preparation for your visit.

- It is very important that you take the time to complete all requested information and mail it back to us no later than 3 days prior to your scheduled appointment. This gives us adequate time to collect needed diagnostic films and/or reports from your physician(s) – e.g., MRIs, x-rays, CT-scans, medical records, etc.
- If you have any questions, regarding the requested data, please contact our office at (702) 839-1203 for assistance.
- If you cannot return the completed information package at least three (3) days prior to your scheduled appointment, please arrive at least 30 minutes before your appointment time to ensure we have the necessary information prepared for your physician/practitioner visit

On the day of your scheduled appointment, please bring the following items with you:

1. Your Nevada Driver Licenses. If you do not have a Nevada licenses, another form of picture identification is required.
2. Your current insurance card(s).
3. An office visit authorization (referral form) from the physician referring you to Centennial Medical Group ***(if required by your current insurance(s).***

Other key information requests include:

* **Attorney Lien activities:** If you have an attorney representing your health care services, please provide the following information:

- The name of the Attorney managing your case.
- The address of your Attorney representative.
- The Attorney's telephone number.
- The date of your injury (You may list this information with your insurance information.)

* **Worker's Compensation activities.** If your health care services involve any type of Worker's Compensation claims, please provide the following information:

- The name of the Insurance carrier that handles your Worker's Compensation claim.
- The mailing address for the Insurance Company.
- The name and telephone number of the Insurance Company Adjuster.
- The date of your injury and your claim number.

Please understand that a $25.00 charge is assessed for any missed appointments, unless a 24-hour notice is given. Missed appointments cause other patients to have to wait for needed services.

CENTENNIAL MEDICAL GROUP

PATIENT DEMOGRAPHICS

Patient Name: First ______ **Middle** ______ **Last** ______ **Date of Birth** ______ **Age** ______ **SEX:** [_] **Female** [_] **Male** **Social Security Number** ______

Mailing Address (Street) ______ **City** ______ **State** ______ **Zip Code** ______ [_] **Single** [_] **Married** [_] **Divorced** [_] **Widowed** [_] **OTHER**

(____) ______ **Home Telephone No** (____) ______ **Work Telephone No** (____) ______ **Mobile Telephone No** [_] **Home** [_] **Work** [_] **Cell Preferred Contact Number** ______ **E-Mail Address**

EMPLOYMENT INFORMATION:

Employer Name ______ **Employer Address: Street** ______ **City** ______ **State** ______ **Zip Code** ______ (___) ______ **Telephone #** ______ **Occupation** ______ [_] **No** [_] **Yes Presently Employed**

EMERGENCY CONTACT:

Emergency Contact Name ______ **Relationship to Patient** ______ (___) ______ **Telephone #** **Type:** [_] **Home** [_] **Work** [_] **Mobile** [_] **Other: Please specify:** ______

Mailing Address (Street) ______ **City** ______ **State** ______ **Zip Code** ______ [_] **Spouse** [_] **Daughter** [_] **Son** [_] **Friend** [_] **OTHER:** ______

(____) ______ **Home Telephone No** (____) ______ **Work Telephone No** (____) ______ **Mobile Telephone No** [_] **Home** [_] **Work** [_] **Cell Preferred Contact Number**

REFERRAL INFORMATION:

How did you hear about Centennial Medical Group? (*Please mark all that apply*)

[_] **TV Ad** [_] **Friend/Acquaintance** [_] **Yellow Pages** [_] **Physician** [_] **Insurance** [_] **Attorney** [_] **OTHER (Please specify):** ______

If referred by Physician: ______ **Name of Physician** ______ **Address: Street** ______ **City** ______ **State Zip Code** ______ (____) ______ **Telephone Number**

INSURANCE:

Patient Relationship to Insurance Subscriber: [_] **Self** [_] **Spouse** [_] **Child** [_] **OTHER:** ______

PRIMARY Insurance

FULL Name of Insurance Subscriber (as listed on Insurance Card) ______ **Subscriber's DOB** ______ **Subscriber SSN#** ______ **Group #** ______ **Identification #** ______ **Co-Payment Amount** ______

Name of Insurance Company ______ **CLAIMS Mailing Address (as noted on back of card)** ______ (___) ______ **Eligibility Telephone #**

Name of Subscriber's Employer ______ **Subscriber's Employer's Address (Street, City, State, Zip code)** ______ (___) ______ **Employer's Telephone #**

SECONDARY Insurance

FULL Name of Insurance Subscriber (as listed on Insurance Card) ______ **Subscriber's DOB** ______ **Subscriber SSN#** ______ **Group #** ______ **Identification #** ______ **Co-Payment Amount** ______

Name of Insurance Company ______ **CLAIMS Mailing Address (as noted on back of card)** ______ (___) ______ **Eligibility Telephone #**

Name of Subscriber's Employer ______ **Subscriber's Employer's Address (Street, City, State, Zip code)** ______ (___) ______ **Employer's Telephone #**

TERTIARY Insurance

FULL Name of Insurance Subscriber (as listed on Insurance Card) ______ **Subscriber's DOB** ______ **Subscriber SSN#** ______ **Group #** ______ **Identification #** ______ **Co-Payment Amount** ______

Name of Insurance Company ______ **CLAIMS Mailing Address (as noted on back of card)** ______ (___) ______ **Eligibility Telephone #**

Name of Subscriber's Employer ______ **Subscriber's Employer's Address: Street** ______ **City** ______ **State, Zip code)** ______ (___) ______ **Employer's Telephone #**

INJURY INFORMATION:

1- If this visit is related to an injury, please complete the following information:

___________ Date of Injury **Type of Injury: [_] Auto [_] Home [_] Work**

2- Has a Worker's Compensation claim been filed? [_] Yes [_] No If YES, please continue with #3.

______________ WC Claim # **_____________________________ Name of Worker's Compensation Carrier** **____________________________________ WC Carrier Address: Street City State Zip Code** **(___)_________ Telephone #**

_________________________ Adjuster Name **____ Address: Street City State Zip Code** **(____)_________ Telephone #**

ATTORNEY INFORMATION:

1- Do you have an attorney representing you? [_] Yes [_] No IF Yes, please continue to #2.

2-________________________ Name of Attorney/Firm **(____)__________ Telephone #** **____ Address: Street City State Zip Code**

3- Have you signed a Medical Lien Agreement with Centennial Medical Group/Surgery Center/Upright MRI? [_]Yes [_]No

ASSIGNMENT OF BENEFITS TO CENTENNIAL MEDICAL GROUP

I directly assign medical benefits otherwise payable to me for the service rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** I hereby authorize the physician/provider to release any information necessary to process my medical claims. I hereby authorize and consent to the medical treatment, testing and procedure that my physician/provider deems advisable and necessary base upon his/her judgment.

____ ______________

PATIENT SIGNATURE DATE

____ ______________

WITNESS SIGNATURE DATE

MEDICAL CARE LIEN AGREEMENT

Patient Name:______________________ **Date of Service:**__________ **Account No:**_____________
Provider: **[_] Dr. David Lanzkowsky** **[_] Dr. Alain Coppel** **[_] Centennial Surgery Center**
[_] Centennial Upright MRI **[_] OTHER:** ____

The "Patient" listed above sustained personal injuries from an accident on or about ________________ hereinafter referred to as "Incident". Patient sought medical care from the above "Provider" located at 4454 N. Decatur Blvd., Las Vegas, NV 89130, for injuries arising from the Incident. Provider agrees to collect all insurance covered amounts from insurance -- other than co pays and deductibles which must be paid by Patient at time of service) UNLESS Patient instructs Provider of their decision to have all services covered by the Lien. Provider will honor the patient's directives provided that Patient and/or Patient's designated Attorney:

(A) Pays all non-covered payer expenses including co-payments and deductible which must contractually be collected prior to service delivery in accordance with the Provider/Payer Agreement to ensure Payer's payment of covered services;

(B) Agrees that any requested payment reduction will be no greater than the representing Attorney's reduction before, during and/or after the Lien Settlement;

(C) Agrees to pay for all rendered and non-collected provided services represented by the Lien amount(s) due to Provider within 15 days of final Lien Settlement unless a written Agreement for payment reduction has been obtained from the Provider/representative.

Patient is asserting a claim ("Claim") against a third-party for compensation in connection with the Incident. Patient hereby assigns and grants to Provider:

(A) All payments for services delivered and covered by the Patient's insurance carrier(s) for which such carrier(s) shall be directed to pay the Provider directly for all rendered services. To the extent Patient's insurance carrier(s) do/does not pay Provider 100% of billed charges (if non-network) or in accordance with Provider's payer's network Agreement, the Patient agrees to pay 100% of all unpaid charges generated for the care of the Patient whether by personal cash or via Lien settlement. Unpaid amounts shall be paid in full within 15 days of the Lien Settlement or the patient/representative(s) shall be sent to a Collections' Agency for payment recovery.

(B) A Lien against the Patient's Claim(s) and any related amounts, which may be recovered by way of settlement, award, judgment, or the like in connection with Patient's Claim(s).

(C) Patient hereby directs their Attorney Representative to withhold from any settlement, award, judgment, or the like relative to Patient's Claim(s) all amounts, which are now or may hereafter become due to Provider as a result of services, care, or treatment provided by Provider to Patient in connection with Patient's Claim(s). Patient further directs Patient's attorney to pay such amounts directly to Provider no later than fifteen (15) calendar days post settlement. Patient consents and directs their attorney that information concerning the status of Patient's Claim(s) shall be provided to Provider upon request. Patient understands and agrees that Provider's rights to payment under this Lien are superior, and take precedence over, Patient's and others' rights to receive any amounts recovered by way of any settlement, award, judgment, or the like in connection with Patient's Claim(s).

Patient fully understands that Patient is directly and fully responsible for payment to Provider for medical care and treatment provided by Provider to Patient relating to the incident. Provider's services are **not** provided on a contingency basis, and are **not** contingent on any settlement, judgment, or verdict. Rather, the Lien granted by this Lien Agreement is made solely for Provider's additional security and in consideration of his pending payment for delivered services.

Patient shall promptly notify Provider if, or in the event, of any change in Patient's Attorney or status in connection with Patient's Claim.

DATED this______ day of_________________, 2008. ______________________________________
Patient Signature

Patient Name: ____________________________

The law firm of ____, "Attorney" represents the above Patient in connection with Patient's Claim. Attorney shall have no liability to Provider to pay any amounts which are or may hereafter become due to Provider for services, treatment, or care furnished by Provider to Patient. Subject to the foregoing, Attorney acknowledges and agrees (to the extent permitted by law and the ethical obligations imposed on Attorney in connection with the practice of law in Nevada) to abide by the terms of Patient's agreement with Provider as set forth in this Lien Agreement.

DATED this ________ day of ________________, 2008.

____
Attorney Signature

CENTENNIAL MEDICAL GROUP

INITIAL PAIN ASSESSMENT BY PATIENT

Please answer the following questions to the best of your ability. Your answers help the physician better understand your pain and the best options for your interventional pain treatment.

Date Form Completed: ___/___/___ Completed by: ______________________________ ________________________
Name (if not patient) Relationship to Patient

Patient Name: ______________________ _________________ ____ ___/___/_____ Sex: [_] [_]
Last First MI Date of Birth Female Male

SSNO: ______________________ Reason for Visit: ____

1- How long has it been since you first started experiencing pain? ____ [_] Days [_] Weeks [_] Months [_] Years

2- When/how did your pain begin? (work/auto accident, spontaneous, slip/fall, surgery, etc.)
____

____

3- Have you had surgery in the past six (6) months? [_] Yes [_] No If yes, what kind? ___________________________

____

4- Throughout our lives, most of us have pain from time to time, such as minor headaches, sprains, toothaches. Have you had pain other than these everyday kinds of pain during the last thirty (30) days? [_] Yes [_] No

4.a. Have you taken pain medication in the last 7 days? [_] Yes [_] No
What pain medication have you taken? ____

What were the results? ____

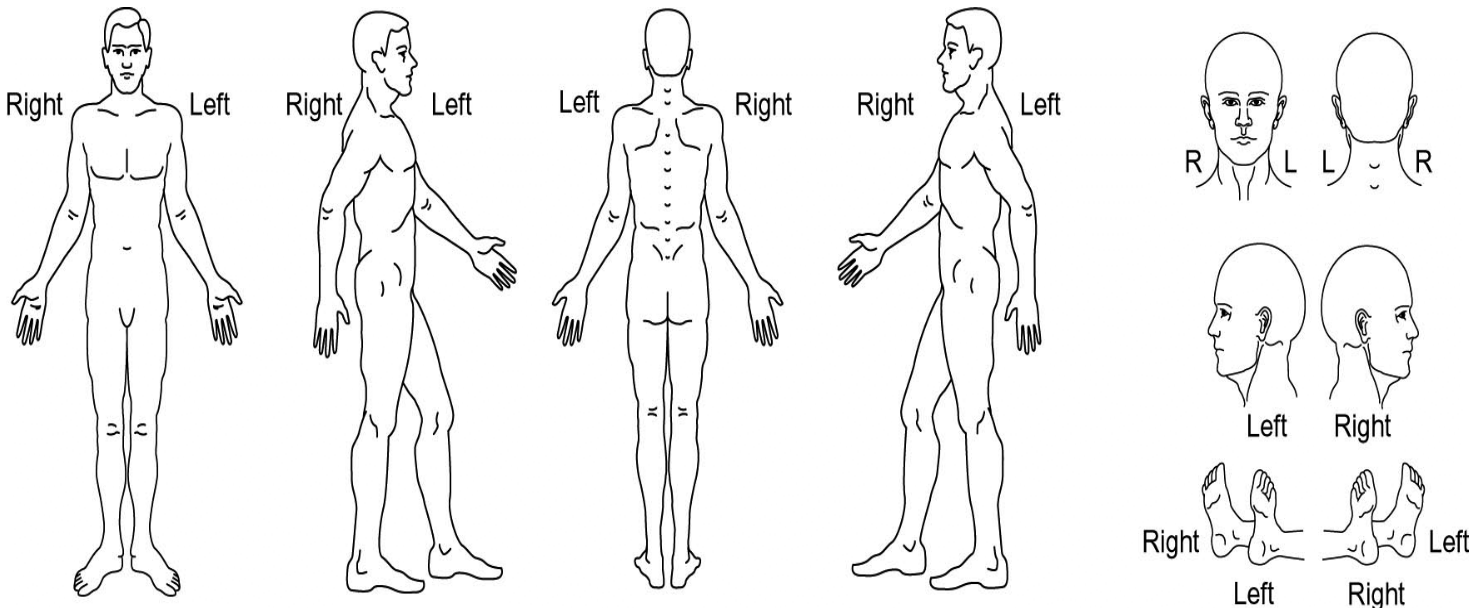
4.b. Do you have some form of pain now that requires medication each and every day? [_] Yes [_] No
What are you currently doing to address your pain? ____

What are your goals for this physician visit? ____

____

5- On the following diagram, **shade** the area where you currently feel pain and indicate the type of symptoms you are feeling.

Numbness ++++++ Pins & Needles: OOOOOOO Burning: XXXXXXXX



Choose the face that best describes how you feel!

0	2	4	6	8	10
No Pain	**Can be Ignored**	**Interferes with tasks**	**Interferes with concentration**	**Interferes with basic needs**	**Bed rest required**

Using the above scale, please answer the following questions:

6- Please rate your pain by circling the one number that best describes your pain at its WORST in past 7 days.

0 1 2 3 4 5 6 7 8 9 10

7- Please rate your pain by circling the one number that best describes your pain at its LEAST in past 7 days.

0 1 2 3 4 5 6 7 8 9 10

8- Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

9- Please rate your pain by circling the one number that best describes your pain RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

10- What kinds of things make your pain feel better (for example: heat, massage, medicine, rest, exercise)?

____

____

11- What kinds of things make your pain worse (for example: walking, lifting, standing, lying, sitting)?

____

____

12- What treatments or medications are you receiving for pain?

____

____

13- In the past 7 days, how much relief have pain treatments or medications provided? Please mark the one percentage that shows how much relief you have received.

[_] 0%-none [_]10% [_]20% [_]30% [_]40% [_]50% [_]60% [_]70% [_]80% [_]90% [_]100%-Total relief

14- If you take pain medication, how many hours does it take before the pain returns?

[_] Pain medication does not help at all [_] 1 hour [_] 2 hours [_] 3 hours [_] 4 hours [_] 5-12 hours
[_] More than 12 hours [_] I do not take pain medication

15- Please check the appropriate answer for each item: I believe my pain is due to:

[_] Yes [_] No A. The effects of treatment (for example: medication, surgery, prosthetic device, health condition).
[_] Yes [_] No B. My primary disease (for example: diabetic neuropathy, injury, illness, post-surgery).
[_] Yes [_] No C. A medical condition unrelated to my primary disease (for example: arthritis, cancer).

16- For each of the following words, check YES or NO if that word describes your pain.

Aching	[_] Yes	[_] No	Burning	[_] Yes	[_] No
Gnawing	[_] Yes	[_] No	Exhausting	[_] Yes	[_] No
Nagging	[_] Yes	[_] No	Numbing	[_] Yes	[_] No
Miserable	[_] Yes	[_] No	Shooting	[_] Yes	[_] No
Stabbing	[_] Yes	[_] No	Sharp	[_] Yes	[_] No
Penetrating	[_] Yes	[_] No	Tender	[_] Yes	[_] No
Tiring	[_] Yes	[_] No	Unbearable	[_] Yes	[_] No
Dull	[_] Yes	[_] No	Squeezing	[_] Yes	[_] No

17- Describe the frequency of your pain. [_] Constant [_] 75% of time [_] 50% of time [_] 25% of time [_] Unsure
- What time of day is your pain the worse? [_] Morning [_] Afternoon [_] Evening [_] Night time

18- Mark ALL of the following symptoms that are associated with your pain:
[_] Numbness [_] Weakness [_] Warmth [_] Coldness [_] Tingling [_] Sweating [_] Swelling [_] Spasms
[_] Changes in skin color [_] Loss of bowel/bladder control

19- Mark ALL of the events that aggravate your pain.
[_] Standing [_] Sitting [_] Lying down [_] Walking [_] Sexual activity [_] Eating [_] Heat [_] Cold
[_] Coughing [_] Sneezing [_] Bending [_] Stretching [_] Stress [_] Work related motion
[_] Other:____

20- Circle the one number that best describes how, during the past 7 days, PAIN has interfered with your:

A. General Activity
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

C. Walking Ability
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

D. Normal Work (includes both work inside (housework) and outside the home
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

E. Relations with Other People
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

F. Sleep
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

G. Enjoyment of Life
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

H. Ability to Concentrate
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

21- I prefer to take my pain medicine: [_] On regular basis [_] Only when necessary [_] Do not take pain medicine

22- I take my pain medicine (in a 24 hour period:
[_] Not every day [_] 1-2 times a day [_] 3-4 times a day [_] 5-6 times a day [_] More than 6 times a day

23- Do you feel you need a stronger type of pain medicine? [_] Yes [_] No [_] Uncertain

If YES, what type of medication? ____

24- Do you feel you need to take more of the medicine than your doctor has prescribed?
[_] Yes [_] No [_] Uncertain

25- Are you concerned you are using too much pain medication? [_] Yes [_] No [_] Uncertain
If YES, why? ____

26- Are you having problems with side effects from your medication? [_] Yes [_] No [_] Uncertain
What type of side effects? ____

27- Other methods I use to relieve my pain include: (Please check all that apply.)
[_] Warm compresses [_] Cold compresses [_] Relaxation techniques [_] Distraction [_] Other drugs
[_] Biofeedback [_] Hypnosis [_] Occasional alcohol [_] Acupuncture [_] Yoga
[_] Alternative medicine: Please specify____
[_] Other: Please specify: ____

28- Medications not prescribed by my doctor that I take for pain are: ___________________________________

____

29- Other drugs or pain agents taken or used not prescribed by my doctor AND FREQUENCY OF USE:

____

____

____

30- What has helped your pain in the past? ____

____

CURRENT TREATMENTS

31- List EACH physician/chiropractor who has treated you for your pain condition and the approximate dates.

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

32- Have you been previously evaluated by a Pain Specialist? (Please provide name, contact number and date)

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

Physician Name: ______________________________ Contact #: (____)________ Dates: ____________________

33- Which of the following treatments have you received? (Please check ALL that apply.)
[_] Nerve blacks / Injections [_] Physical therapy [_] TENS [_] Exercise [_] Psychological treatment
[_] Surgery [_] Surgery [_] Biofeedback [_] Acupuncture [_] Chiropractor
[_] Cane/Walker [_] Massage [_] Brace/Support [_] Relaxation [_] Epidural injection
[_] Facet injection [_] Spinal stimulator [_] Morphine pump
[_] Alternative medicine: ___________________ [_] Other: _____________________________

34- Please list ALL previous testing: (Please check ALL that apply.)

Please provide dates and facility for each test so we can request them prior to your scheduled visit.

[_] X-Ray: Area(s): ____________________ Date: _____________ Facility: _______________________

____

[_] MRI: Area(s): ______________________ Date: _____________ Facility: _______________________

____

[_] CT Scan: Area(s): __________________ Date: _____________ Facility: _______________________

____

[_] Myelogram: Area(s): ________________ Date: _____________ Facility: _______________________

____

[_] EMG (Nerve conduction) Date: _____________ Facility: _______________________

Area(s): _____________________

____

[_] Bone Scan: Area(s): _______________ Date: _____________ Facility: _______________________

____

[_] Discogram: Area(s): _______________ Date: _____________ Facility: _______________________

____

[_] Other: __________________________ Date: _____________ Facility: _______________________

____

Which treatments have you had or are now receiving? (Ex: medications, physical therapy, acupuncture, TENS unit, etc.). Please list them, and circle the number to signify the amount of relief they provide or have provided.

Treatment/Medication	No Relief										Complete Relief	Receiving Treatment
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No
__________________________	0	1	2	3	4	5	6	7	8	9	10	Yes No

CENTENNIAL MEDICAL GROUP

Medical, Family & Social History

___/___/___ **Name:** ________________________ ___________________ ____ ___/___/_____ **Sex:** [_] [_]
Date **Last** **First** **MI** **Date of Birth** **Female** **Male**

Do you have a primary care physician? [_] Yes [_] No

If yes, please list name and contact info: ____
Name Location Phone Number

PAST SURGICAL HISTORY

Surgeries / Hospitalizations	Year	Complications
_______________________________	_____	____
_______________________________	_____	____
_______________________________	_____	____
_______________________________	_____	____
_______________________________	_____	____
_______________________________	_____	____

CURRENT MEDICATIONS

- **Are you taking narcotic (opioid) medications?** [_] Yes [_] No
- **Are you taking muscle relaxers?** [_] Yes [_] No
- **Are you taking sleeping aid medications?** [_] Yes [_] No
- **Are you taking blood thinners?** [_] Yes [_] No
- **Are you taking diabetic medications or insulin?** [_] Yes [_] No
- **Are you taking blood pressure medications?** [_] Yes [_] No
- **Are you taking anti-anxiety medications?** [_] Yes [_] No
- **Are you taking anti-depressant medications?** [_] Yes [_] No
- **Are you taking anti-psychotic medications?** [_] Yes [_] No

Please list ALL medications you are CURRENTLY taking:

Medication	→	Dose & Frequency	Medication	→	Dose & Frequency
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________
______________		______________________	______________		______________________

DRUG ALLERGIES:

Medication	→ Reaction	Medication	→ Reaction	Medication	→ Reaction
___________	___________	___________	___________	___________	___________
___________	___________	___________	___________	___________	___________
___________	___________	___________	___________	___________	___________

Drug Intolerances:

Medication	→ Reaction	Medication	→ Reaction	Medication	→ Reaction
___________	___________	___________	___________	___________	___________
___________	___________	___________	___________	___________	___________
___________	___________	___________	___________	___________	___________

PERSONAL MEDICAL HISTORY

PAST MEDICAL HISTORY: (Please check ALL that apply.)

[_] Coronary artery disease	[_] Stroke / TIA	[_] COPD	[_] Hepatitis	[_] Kidney disorder
[_] Heart attack	[_] Seizures	[_] Emphysema	[_] HIV	[_] Liver disorder
[_] Heart failure	[_] Hiatal hernia	[_] Asthma	[_] Blindness	[_] Thyroid disorder
[_] Hypertension	[_] Heartburn	[_] Lupus	[_] Paralysis	[_] Psychiatric disorder
[_] Valve Problems	[_] Ulcers	[_] History of Cancer	[_] Blood disorder	[_] Abnormal bleeding

[_] OTHER MAJOR ILLNESSES: ____

REVIEW OF SYSTEMS

	Please mark YES or NO	
	YES	**NO**
General		
Fever	[_]	[_]
Weight Loss	[_]	[_]
Excessive Fatigue	[_]	[_]
Night sweats	[_]	[_]
Eyes		
Wear Glasses	[_]	[_]
Infections	[_]	[_]
Injuries	[_]	[_]
Glaucoma	[_]	[_]
Cataracts	[_]	[_]
Ear, Nose, Throat & Mouth		
Hearing Loss	[_]	[_]
Ear Pain	[_]	[_]
Ear Infections	[_]	[_]
Ringing in Ears [_] LEFT [_] RIGHT [_] BOTH	[_]	[_]
Balance Disturbance (vertigo/spinning)	[_]	[_]
Nosebleeds	[_]	[_]
Nasal congestion	[_]	[_]
Nasal drainage – Amount__________ Color ___________	[_]	[_]
Inability to smell	[_]	[_]
Sinus Problems	[_]	[_]
Sinus Headaches	[_]	[_]
Sore Throats	[_]	[_]
Mouth Sores	[_]	[_]

	Please mark YES or NO	
Cardiovascular	**YES**	**NO**
Chest pain or Angina – Date of last EKG: _______________	[_]	[_]
High Blood Pressure	[_]	[_]
Irregular Pulse	[_]	[_]
Heart Murmur	[_]	[_]
High Cholesterol	[_]	[_]
Swelling in Feet or Hands	[_]	[_]
Leg Pain while walking	[_]	[_]
Respiratory		
Asthma	[_]	[_]
Chronic Cough	[_]	[_]
Emphysema	[_]	[_]
Shortness of Breath	[_]	[_]
Obstructive Sleep Apnea	[_]	[_]
Bronchitis	[_]	[_]
Pneumonia	[_]	[_]
Lung Cancer	[_]	[_]
Bloody Sputum	[_]	[_]
Date of last chest x-ray ____________________________	[_]	[_]
Gastrointestinal		
Indigestion or Pain with eating	[_]	[_]
Nausea	[_]	[_]
Vomiting	[_]	[_]
Bloody Vomit	[_]	[_]
Liver disease	[_]	[_]
Jaundice	[_]	[_]
Change in bowel habits	[_]	[_]
Ulcers or Gastritis	[_]	[_]
Colon Cancer	[_]	[_]
Eating Disorder	[_]	[_]
Genitourinary		
Urinary tract infections	[_]	[_]
Pain on urination	[_]	[_]
Blood in your urine	[_]	[_]
Difficulty in Starting or Stopping Urine	[_]	[_]
Incontinence	[_]	[_]
Kidney Stones	[_]	[_]
Prostate Cancer (Males)	[_]	[_]
Endometriosis (Females)	[_]	[_]
Uterine or Cervical Cancer (Females)	[_]	[_]
Musculoskeletal		
Broken Bones – List: ____	[_]	[_]
Arm or Leg Pain	[_]	[_]
Back Pain	[_]	[_]
Joint Pain or Swelling	[_]	[_]
Osteoarthritis	[_]	[_]
Rheumatoid Arthritis	[_]	[_]
Skin / Integumentary		
Skin Disease – List ____	[_]	[_]
Skin Cancer	[_]	[_]
Neurological		
Fainting Spells or “Blacking Out” or Seizures	[_]	[_]
Problems with Memory	[_]	[_]
Headache	[_]	[_]
Difficulty with Speech	[_]	[_]
Inability to Concentrate, Disorientation	[_]	[_]
Double or Blurred Vision	[_]	[_]
Facial Weakness	[_]	[_]
Poor coordination of Arms or Legs	[_]	[_]

Psychiatric	Please mark YES or NO YES	NO
Anxiety	[_]	[_]
Depression	[_]	[_]
Bipolar	[_]	[_]
Schizophrenia	[_]	[_]
Post traumatic stress disorder	[_]	[_]
Previous suicide attempts	[_]	[_]
Current suicidal thoughts	[_]	[_]
Other: ____	[_]	[_]

My current psychiatrist/psychologist is: ____________________________________
Name Locations Phone

Endocrine	YES	NO
Diabetes	[_]	[_]
Hemophilia or Bleeding Tendencies	[_]	[_]
Abnormal Clotting	[_]	[_]
Persistent Swollen Glands	[_]	[_]
Blood Transfusion, When: ______________________	[_]	[_]

Allergic / Immunologic	YES	NO
Food Allergies (including Shell Fish)	[_]	[_]
Environmental Allergies	[_]	[_]
Latex Allergies	[_]	[_]
Iodine Allergies	[_]	[_]
Immunologic Disorders, LIST: ____	[_]	[_]

FAMILY MEDICAL HISTORY

FAMILY HISTORY	LIVING		AGE	HEALTH STATUS OR CAUSE OF DEATH
Maternal Grandmother	[_] Yes	[_] No	____	____
Maternal Grandfather	[_] Yes	[_] No	____	____
Paternal Grandmother	[_] Yes	[_] No	____	____
Paternal Grandfather	[_] Yes	[_] No	____	____
Father	[_] Yes	[_] No	____	____
Mother	[_] Yes	[_] No	____	____
Sister/Brother	[_] Yes	[_] No	____	____
Sister/Brother	[_] Yes	[_] No	____	____
Sister/Brother	[_] Yes	[_] No	____	____
Sister/Brother	[_] Yes	[_] No	____	____
Sister/Brother	[_] Yes	[_] No	____	____

- Do you have a family history of alcohol abuse, illegal drugs, or prescription medications? [_] Yes [_] No

SOCIAL HISTORY

1- Marital Status (at present): [_] Single [_] Married [_] Widowed [_] Separated/Divorced

2- Education: Check only the highest grade or degree completed:

Grade [_]0 [_]1 [_]2 [_]3 [_]4 [_]5 [_]6 [_]7 [_]8 [_]9 [_]10 [_]11 [_] 12 [_]College [_]Graduate School

Professional Degree (please specify): ________________________

3- Which of the following best describes your current job status?

[_] Full time [_] Part time [_] Homemaker [_] Retired [_] Unemployed [_] Fully disabled

[_] Other: __________

If Employed: ____

Current Occupation Job Title Employer Months or Years at current job

If Not Currently Working: ____

Date of last job Job Title Employer Reason for leaving

If Fully Disabled: ____

Date and Reason for disability

4- Spouse's Occupation: ____________________________

5. Please complete the following information on ALL people that live with you.

Name	Relationship	Brief description of their health
___________________	________________	____
___________________	________________	____
___________________	________________	____
___________________	________________	____
___________________	________________	____
___________________	________________	____

6. Do you smoke?

[_] Yes, I've smoked ______ packs of cigarettes for _____ years.

[_] Yes, I smoke cigars or a pipe.

[_] No, I have never smoked.

[_] No, I quit _____ years ago, at that time I was smoking _____ packs per day.

7. Do you drink alcohol?

[_] No

[_] Yes, I drink ___________ beers or drinks per _______________.

[_] I used to drink ___________ beers or drinks per ________, but I quit.

8. Do you currently have or are at risk for HIV/AIDS or Hepatitis?

[_] Decline to answer

[_] No

[_] Yes, explain: ____

9. Have you ever used recreational or street drugs?

[_] Yes, I currently use _________________________; Frequency: ______________________________

[_] Yes, but have not used any in the last ____

[_] Yes, have tried ____

[_] No

10. Have you ever been treated for drug or alcohol abuse?

[_] Yes, completed treatment(s).

[_] Yes, started treatment, but did not finish it.

[_] No

11. Have you ever been advised or thought that you should seek drug or alcohol rehabilitation/treatment?

[_] Yes, have been advised.

[_] Yes, have thought about seeking treatment but have not.

[_] No

12. Have you ever been the victim of physical, sexual, psychological, or emotional abuse?

[_] Yes [_] No

13. Are you currently the victim of physical, sexual, psychological, or emotional abuse?

[_] Yes [_] No

SUBSTANCE USE

Place an "X" in the box next to the substance you ***have*** or **currently use**. Next to the substance, please indicate the frequency of use: **"0"- Occasional,** **"F"- Frequently** **"C"- Continuously**

Substance	Past Use	Length of Time Used	Current Use
• Alcohol	[___]	____________________	[___]
• Amphetamines	[___]	____________________	[___]
• Barbiturates	[___]	____________________	[___]
• Cocaine	[___]	____________________	[___]
• Heroine	[___]	____________________	[___]
• Marijuana	[___]	____________________	[___]
• Other (specify) ______________	[___]	____________________	[___]
• ____________________________	[___]	____________________	[___]
• ____________________________	[___]	____________________	[___]
• ____________________________	[___]	____________________	[___]

The above information is accurate to the best of my knowledge.

____ __________________

Patient Signature **Date**

I have reviewed the above patient provided information with the patient.

____ _______________________

Physician Signature

CENTENNIAL MEDICAL GROUP
David Lanzkowsky, M. D. -- Alain Coppel, M. D. -- Christopher Curtis, PA-C – James Boesiger, PA-C
4454 N. Decatur Blvd. Las Vegas, Nevada 89130
6030 S. Rainbow Blvd. Bldg. D Ste. B, Las Vegas, Nevada 89118
4640 W. Craig Road, Las Vegas, Nevada 89032
2637 W. Horizon Ridge Parkway, Ste. 110, Henderson, Nevada 89052
Main Office: (702) 839-1203 Main Fax: (702) 839-1301

RECORDS RELEASE

Date of Request:_______________________________

Last Name:____________________________ First Name:________________________

Patient's Address: ____

City, _______________________________ State, ________Zip:____________________

Date of Birth: ____________________ Social Security Number:______________________

I hereby authorize and request that you release all records including x-rays and other tests to: ____
____
____

If specific date needed please list date____

____________________________________ ___________
Patient Signature Date

CENTENNIAL MEDICAL GROUP
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HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

______________________________ ______________
Patient Name **Date**

______________________________ ______________
Patient or Representative Signature **Date**

I authorize the following individual(s) to obtain my personal/medical information.

______________________ ______________________
Name **Relationship**

______________________ ______________________
Name **Relationship**

______________________ ______________________
Name **Relationship**

______________________ ______________________
Name **Relationship**

Centennial Medical Group
DL-JT dba Centennial Surgery Center

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMA TION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act, (HIPAA). This privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your, "protected health information," "means any written or oral health information about you, including demographic data that can be used to identify you." This is health information that is created or received by your health care provider, and that related to your past, present or future physical or mental health or condition.

I. **Uses and Disclosures of Protected Health Information**
Centennial Medical Group, LLP and Centennial Surgery Center may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third part for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with this or another facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of other provider.

B. **Payment.** Your protected health information may be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for their utilization and review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the identified organizations and to provide quality care to all patients. Health care operations include such activities as**:** quality assessment and improvement activities, employee review activities training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical review, legal services and maintaining compliance programs,

and business management and general administrative acetifies. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your surgery date, to inform you of potential treatment alternative or options, to inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institutional foundation related to facility. If you do not wish to be contacted regarding fund-raising, please contact our Privacy Officer.

11. **Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object.**
Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required: We will disclose your protected health information when we are required to do so by any federal, state or local law.

B. When There Are Risks to Public Health: We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track **FDA** regulated products, enable product recalls, repairs or replacement to the **FDA** and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer, information about an individual who is a member of the work force as legally permitted or required.

C. To Report Suspended Abuse, Neglect or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigation, proceedings, or actions; inspections; licensure pr disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

E. In Connection With Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material, witness or missing person.
- Under certain limited circumstances, when are you the victim of a crime.

- To law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or of the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. **For Research Purposes.** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. **In the Event of a Serious Threat to Health or Safety.** We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **For specified Government Functions.** In certain circumstance, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation.** The facility may release your health information to comply with worker's compensation laws or similar programs.

III. **Uses and Disclosures Permitted without Authorization but with Opportunity to Object.**
We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate family members or others involved in your care concerning your location, condition or death. You may object to these disclosures. Please object in writing if you wish to do so. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. **Uses and Disclosures which you Authorize.**
Other than as stated above, we will not disclose your health information other that with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. **Your Rights.**
You have the following rights regarding your health information.

A. The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. **A** "designated record set" contains medical and billing records and nay other records that you surgeon and the facility uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health

information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in out professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision. To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of the Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Office if you have questions about access to your medical records.

B. The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclosed certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specifications of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to out Privacy Officer.

D. The right to request amendments to your protected health information. You may request an amendment of protected health information about you in a designated record to set for **as** long **as** we maintain this information. In certain cases, we may 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 any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to fiends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer.

The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting request may be subject to a reasonable cost-based fee.

F. The right to obtain a Paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. **Our Duties**
The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

VII. **Complaints**
You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below.

We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for &g a complaint.

VIII. **Contact Person**
The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Office. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If YOU feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

Privacy Officer
Centennial Medical Group
DL-JT dba Centennial Surgery Center
4454 North Decatur Blvd.
Las Vegas, NV 89130
ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at 702-839-1203

IX: **Effective Date**: 2003
Revised Date: 7/14/2008