Waseem Alhushki, MD
Kanyalakshmi Ayyanar, MD
Arlene Bayreder, APRN
Danielle Bello, PhD
Angela Berg, DNP, CPNP
Diane Brown, MD, PhD
Daisy Cortes, MD
Amber Federizo, APRN, FNP-BC

Erin Foster, APRN, FNP-BC
Alan Ikeda, MD
Nicola Longo, MD, PhD
Lisa Majlessi, MD
Katherine Marzan, MD
Nik Abdul Rashid, MD
Alexandra Walsh, MD

Welcome to the offices of Children's Specialty Center of Nevada. We appreciate the confidence and trust that you have placed in our office and look forward to meeting you personally and professionally. Our goal is to provide the highest quality care in a friendly, caring and efficient environment.

It is also our goal to provide you timely visits with your physicians. Please arrive on time to your appointment with paperwork completed to avoid the risk of your appointment being rescheduled.

We ask that you bring the following items to our office for your first visit:

- All over-the-counter, herbal and prescription medications that the patient is taking
- Current insurance card & driver's license or government issued photo ID
- CD/Films for any CT scans, ultrasounds or testing you have had done

Our Las Vegas office is located at 3121 S. Maryland Parkway, Suite 300, Las Vegas, NV 89109 (closest intersection is Desert Inn and Maryland Parkway). The Las Vegas HTC office is located at 3121 S. Maryland Parkway, Suite 206, Las Vegas, NV 89109. Our Reno office is located at 540 Plumb Lane, Suite 200, Reno, NV 89509 between S. Arlington Ave. and Plumas St.

Should you have any questions or need any additional information please don't hesitate to call our office at 702-732-1493.

We look forward to seeing you at our office. Thank you for giving us the opportunity to serve you.

Sincerely,

The Staff of Children's Specialty Center of Nevada & Hemophilia Treatment Center of Nevada

Children's Specialty Center of Nevada
3121 S. Maryland Parkway #300/#216
Las Vegas, NV 89109
Phone: (702) 732-1493
Fax: (702) 732-1080
Medical Records Fax: (702) 862-4981

Hemophilia Treatment Center of Nevada
3121 S. Maryland Parkway #206
Las Vegas, NV 89109
Phone: (702) 732-1956
Fax: (702) 732-3225

Children's Specialty Center of Nevada &
Hemophilia Treatment Center of Nevada
540 W. Plumb Lane #200
Reno, NV 89509
Phone: (775) 657-8981
Fax: (775) 657-8317

Patient Name _____ **Date of Birth** _____

Waseem Alhushki, MD
Kanyalakshmi Ayyanar, MD
Arlene Bayreder, APRN
Danielle Bello, PhD
Angela Berg, DNP, CPNP
Diane Brown, MD, PhD
Daisy Cortes, MD
Amber Federizo, APRN, FNP-BC

CHILDREN'S SPECIALTY CENTER OF NEVADA

Erin Foster, APRN, FNP-BC
Alan Ikeda, MD
Nicola Longo, MD, PhD
Lisa Majlessi, MD
Katherine Marzan, MD
Nik Abdul Rashid, MD
Alexandra Walsh, MD

Patient Registration & Insurance Information

Please verify patient's information and change if incorrect. The front desk is available if you have any questions.

ALL ITEMS MUST BE COMPLETED – DO NOT LEAVE ANY BLANKS

PATIENT INFORMATION

PATIENT LAST NAME	**FIRST NAME**	**MIDDLE INIT**	**SSN**	**SUFFIX**
ADDRESS 1		**CITY**	**STATE**	**ZIP**
HOME TEL #	**WORK TEL #**	**CELL #**	**SEX**	**AGE**
BIRTHDATE	**EMPLOYER**	**E-MAIL ADDRESS**		
USUAL PROVIDER	**REFERRING PHYSICIAN**	**PRIMARY CARE PHYSICIAN**		
MARITAL STATUS	**EMPLOYMENT STATUS** ☐ Full ☐ Part ☐ Retired ☐ Unemployed	**STUDENT STATUS** ☐ Full Time ☐ Part Time ☐ Not a Student	**REL TO GUARANTOR**	
PREFERRED PHARMACY & LOCATION (INTERSECTION)	**PREFERRED PHARMACY PHONE #**			
ETHNICITY *(select 1)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Refused	**LANGUAGE** ☐ English ☐ Spanish ☐ _____	**INTERPRETER NEEDED** ☐ Yes ☐ No		
RACE *(select 1)* ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Japanese ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Unknown/Refused				

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
CARRIER NAME		**CARRIER NAME**	
CARRIER ADDRESS		**CARRIER ADDRESS**	
CERTIFICATE ID #		**CERTIFICATE ID #**	
GROUP NAME		**GROUP NAME**	
CLAIM/GROUP NO		**CLAIM/GROUP NO**	
CARRIER PHONE #		**CARRIER PHONE #**	
SUBSCRIBER NAME		**SUBSCRIBER NAME**	
SUBSCRIBER D.O.B.		**SUBSCRIBER D.O.B.**	
SUBSCRIBER SSN		**SUBSCRIBER SSN**	
RELATIONSHIP TO PATIENT		**RELATIONSHIP TO PATIENT**	

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)

GUARANTOR LAST NAME	**FIRST NAME**	**MIDDLE INIT**	
ADDRESS	**CITY**	**STATE**	**ZIP**
HOME TEL #	**WORK TEL #**	**CELL #**	**E-MAIL ADDRESS**

EMERGENCY CONTACT INFORMATION

1	**EMERGENCY CONTACT #1**			**SUFFIX**
	PHONE #1	**PHONE #2**	**PHONE #3**	**RELATIONSHIP TO PATIENT**
2	**EMERGENCY CONTACT #2**			**SUFFIX**
	PHONE #1	**PHONE #2**	**PHONE #3**	**RELATIONSHIP TO PATIENT**

Patient Health History Questionnaire

Please help us be as efficient as possible with your first visit to our clinic. This health history questionnaire **must** be completed prior to your appointment. Should you need assistance with answers to any of the questions asked, feel free to contact our office and we will be happy to help you.

Health history questionnaires that are incomplete or forgotten at the time of your appointment and/or arriving late for your appointment may result in rescheduling of your appointment.

TODAY'S DATE	**DATE OF LAST PHYSICAL EXAM** ☐ Unknown

Mail Order Pharmacy (if applicable)	
Name	**Address**
Phone	**Fax**

Reason For Visit What is the main reason the patient is seeing the doctor today?
☐ Referred by Hospital or Other Provider. **Who?**

Past Medical History Has patient ever been **DIAGNOSED** with any of the following problems? If yes, please explain.					
		DATE OF ONSET	**DATE OF TESTING**	**COMMENTS**	**RESOLVED?**
AIDS	☐ Yes ☐ No				☐
HIV Positive	☐ Yes ☐ No				☐
Tuberculosis	☐ Yes ☐ No				☐
Arthritis	☐ Yes ☐ No				☐
Cancer	☐ Yes ☐ No				☐
Indicate type(s)					☐
Diabetes	☐ Yes ☐ No				☐
Insulin Dependent (Type I)	☐ Yes ☐ No				☐
Non Insulin Dep (Type II)	☐ Yes ☐ No				☐
Gout	☐ Yes ☐ No				☐
Heart Disease	☐ Yes ☐ No				☐
Indicate type(s)					☐
Hepatitis	☐ Yes ☐ No				☐
High Blood Pressure	☐ Yes ☐ No				☐
Neurological Problems	☐ Yes ☐ No				☐
Rheumatic Fever	☐ Yes ☐ No				☐
Sexually Transmitted Disease	☐ Yes ☐ No				☐
Stomach or Intestinal Problems	☐ Yes ☐ No				☐
Urinary Tract Infections	☐ Yes ☐ No				☐
Other	☐ Yes ☐ No				☐

Allergies List patient's allergens and associated reactions (e.g. Hives, Rash, Nausea…)					
☐ **No Known Drug Allergies**					
☐ **No Known Food Allergies**			List other drug, food, environmental allergens & associated reactions		
Allergen & Allergic (Y/N)		**Reaction**	**Allergen & Allergic (Y/N)**		**Reaction**
Aspirin	☐ Yes ☐ No			☐ Yes ☐ No	
Morphine	☐ Yes ☐ No			☐ Yes ☐ No	
Penicillin	☐ Yes ☐ No				
Sulfa	☐ Yes ☐ No				
Latex	☐ Yes ☐ No				
Adhesive tape	☐ Yes ☐ No				

Family History Check if patient's blood relatives have had any of the following, If yes, please specify.						
☐ **Family Medical History Unknown**						
	Mother	**Father**	**Sister(s)**	**Brother(s)**	**Other**	**Please Mark if Not Present**
Age						
Health State (Good, Fair, Poor)						
Age of Death						
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Blood Clot	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐
Heart Disease-Type:	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Intestinal Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐
Neurologic Disorder	☐	☐	☐	☐	☐	☐
Premature Death	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Suicide Attempt	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Medications: Please list patient's medications including aspirin, vitamins, over-the-counter, or herbal medications.					
Medication Name	**Dose**	**Frequency & Reason**	**Medication Name**	**Dose**	**Frequency & Reason**
			Aspirin		
			Coumadin/Warfarin		
			Hormones or birth control		
			Herbal supplements		
			Vitamins		

Social History of Patient:	
Single parent household ☐ Yes ☐ No ☐ Not Applicable	**Split custody?** ☐ Yes ☐ No ☐ Not Applicable
Who lives in household with child ☐ Mother ☐ Father ☐ Siblings ☐ Others _____	
Are there any safety concerns in the household? ☐ Yes ☐ No	
Lives in ☐ House ☐ Apartment ☐ Trailer ☐ Other _____	
Smokers in household? ☐ Yes ☐ No	**Caretaker smokes?** ☐ Yes ☐ No
School? ☐ Day care ☐ Preschool ☐ Home school ☐ Traditional school Grade _____	
Extra-curricular activities ☐ Sports ☐ Arts ☐ Crafts ☐ Other _____	
Does the patient use alcohol? ☐ Yes ☐ No	**Does the patient use tobacco?** ☐ Yes ☐ No

Birth History of Patient:
Pregnancy/medical problems ☐ Yes ☐ No If yes, please describe _____
Delivery ☐ Normal ☐ Prolonged ☐ Difficult ☐ Vaginal ☐ C/Section ☐ Breech ☐ VBAC ☐ Other _____
Birth ☐ Full term ☐ Premature Number of weeks _____

Past Surgical History or Hospital Stays for Patient:		
History of anesthesia problems? ☐ Yes ☐ No If yes, list type and reactions _____		
Year	**Procedure/Illness**	**Surgeon/Location**

Recent Imaging and Diagnostic Studies for Patient: (CT, X-ray, Ultrasound, MRI, etc.)			
Year	**Type**	**Body Part**	**Facility**
	CT Scan		
	X-Ray		
	MRI		
	Ultrasound		

Review of Systems: Please tell us about the patient's **current symptoms**.					
*** General**		*** Cardiovascular**		*** Musculoskeletal**	
Normal: Activity Level	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Back Pain	☐ Yes ☐ No
Normal Appetite	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No
Normal Sleep	☐ Yes ☐ No	Palpitations	☐ Yes ☐ No		
Normal Growth/Development	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	*** Neurological**	
Normal Speech/Language	☐ Yes ☐ No			Fainting	☐ Yes ☐ No
		*** Gastrointestinal**		Serious Head Injuries	☐ Yes ☐ No
*** Skin**		Abdominal Pain	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Acne	☐ Yes ☐ No	Constipation	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Concerning Moles/Bumps	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No		
Rash	☐ Yes ☐ No	Vomiting	☐ Yes ☐ No	*** Psychiatric**	
				Uncooperative/Defiant	☐ Yes ☐ No
***Head & Neck (HEENT)**		*** Genitourinary**		Anxious/Depressed	☐ Yes ☐ No
Frequent Headaches	☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No	Difficulty with Teachers	☐ Yes ☐ No
Vision Problems	☐ Yes ☐ No	Concerns w/ Bladder Control	☐ Yes ☐ No	Difficulty with Children	☐ Yes ☐ No
Hearing Problems	☐ Yes ☐ No	Concerns w/ Bowel Control	☐ Yes ☐ No		
Itchy Watery Eyes	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	*** Endocrine/Hematopoietic**	
Stuffy Nose	☐ Yes ☐ No	Concerns w/ Sexual Development	☐ Yes ☐ No	Difficulty with Heat	☐ Yes ☐ No
Neck Pain	☐ Yes ☐ No	Side (flank) Pain	☐ Yes ☐ No	Difficulty with Cold	☐ Yes ☐ No
		Urinary Complaints	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No
*** Respiratory**				Excessive Urination	☐ Yes ☐ No
Cough	☐ Yes ☐ No	*** Females Only**		Easy Bruising	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Missed Periods	☐ Yes ☐ No		
		Menstrual Irregularities	☐ Yes ☐ No		

Please list any doctors that you are currently seeing as a patient:			
Doctor's Name	**Phone Number** *(if known)*	**Type of Doctor**	**Condition Being Treated**

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Patient Name: _____ **Date of Birth:** _____

If you have insurance, Children's Specialty Centers of Nevada (CSCN) will gladly process your claim. However, we require that your estimated portion is paid when services are rendered.

IF YOU ARE NOT COVERED BY INSURANCE, we will provide an estimate of the cost of your care. This estimate will include anticipated charges based on the recommended treatment plan. If your plan of treatment changes, you may be asked to agree to a new estimate and estimates may vary due to a variety of factors.

If you are a **SELF-PAY** patient or if you have a financial obligation after your insurance has fulfilled its responsibility, you will be expected to pay the balance due. If you cannot pay your balance in full, payment arrangements may be possible. For payment options, including sliding fee scales, you must speak with our Business Office Representative.

For further understanding of our billing process, please feel free to contact a member of the business office staff.

Please initial each line:

_____ I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to CSCN for all pharmaceuticals, tests, procedures, equipment, supplies, physician/nursing services--including major medical benefits, or services provided to me by CSCN.

_____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to CSCN, my insurance carrier, state, federal accreditation agency, or other medical entity. A copy of this authorization will be sent to my insurance carrier, or other medical entity, if requested. The original authorization will be kept on file by CSCN. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within CSCN.

_____ I understand that it is my responsibility to notify CSCN of any changes in my health care coverage, insurance carrier, change of address, change of employer or any change in legal guardianship of the minor/patient.

_____ I understand that I am financially responsible to CSCN for any charges not covered by health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by CSCN and/or my health care insurer, if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility and am agreeing to pay for any/all above described medical services received. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service.

_____ I understand that there is a **$25.00** charge for all returned checks.

_____ I understand that there is a **$25.00** charge for all missed or cancelled appointments that are not cancelled within 24 hours of the scheduled appointment time.

** THIS ACKNOWLEDGEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING **

*By signing this document, I also acknowledge that I have been made aware of CSCN's **Notice of Privacy Practices**, as is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights as well as **Understanding our Billing Process**. I have read and, if requested, received a copy of the above statement and Privacy Practices and accept the terms. A duplicate or facsimile transmission of this statement is considered the same as original.*

Signature of Insured/Parent/Guardian: _____ **Date Signed:** _____/_____/_____

Print Name of Insured/Parent/Guardian: _____

AUTHORIZATION OF TREATMENT AND DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth: _____**

I authorize **Children's Specialty Centers of Nevada (CSCN)** and **Hemophilia Treatment Center of Nevada** to treat myself or my child as needed and not hold them responsible for any decisions made in an emergency situation.

No medical information with any third parties will be discussed, unless written consent/authorization has been obtained. This includes discussion by telephone, facsimile, letter, email or in person. This consent form gives CSCN permission to discuss medical information for the purpose of administering health care related activities. I hereby agree that Protected Health Information (PHI) may be released by CSCN as stated in our clinic's '***Notice of Privacy Practices***.'

I authorize *only* the following individual(s) to accompany minor child/patient to appointments and receive Protected Health Information (PHI) concerning the above named minor child/patient (act as "personal representative(s)" or loco parentis for the above named minor child/patient), in accordance with NRS 129.030 - 129.040:

Printed Name: _____ **Relationship to Patient: _____**

Printed Name: _____ **Relationship to Patient: _____**

I further certify that I am the legal parent/guardian of the above named minor child/patient.

Signature of Insured/Parent/Guardian: _____ Date Signed: _____/_____/_____

Print Name of Insured/Parent/Guardian: _____

Employee Witness: _____

AUTHORIZATION TO RELEASE PATIENT MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____

Release Information to:

☐ Las Vegas

Children's Specialty Center of Nevada
3121 S. Maryland Parkway #300/#216
Las Vegas, NV 89109
Phone: (702) 732-1493
Fax: (702) 732-1080
Medical Records Fax: (702) 862-4981

☐ Las Vegas HTC

Hemophilia Treatment Center of Nevada
3121 S. Maryland Parkway #206
Las Vegas, NV 89109
Phone: (702) 732-1956
Fax: (702) 732-3225

☐ Reno Location

Children's Specialty Center of Nevada & Hemophilia Treatment Center of Nevada
540 W. Plumb Lane #200
Reno, NV 89509
Phone: (775) 657-8981
Fax: (775) 657-8317

Release:
☐ All Records ☐ Labs/Radiology ☐ Notes

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Children's Specialty Centers of Nevada (CSCN) in writing. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Nevada privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Printed Name of Person Requesting: _____ **Phone Number:** (_____) _____ - _____

Relationship to Patient: ☐ Patient ☐ Parent ☐ Guardian ☐ Other _____

Authorizing Signature: _____ **Date of Signature:** _____/_____/_____

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE SIGNED UNLESS I SPECIFY ANOTHER DATE: _____/_____/_____.