PLEASE NOTE:

YOUR DATE OF PROCEDURE IS:

_____

TIME TO ARRIVE AT FACILITY IS:

_____

ADDRESS: **VALLEY VIEW SURGERY CENTER**
1330 S. VALLEY VIEW BLVD
LAS VEGAS, NV 89102
Ph: 702-675-4600

All the forms in this packet are also available on website.

https://valleyviewsurgerycenterlv.com

→ Attention ←

ALL patients having services at Valley View Surgery Center With Sedation / Anesthesia

MUST

Have a responsible adult to Accompany the patient home.

Transportation such as Uber, Lyft, taxi, city bus or other public transportation is not acceptable if a responsible adult is not *with the patient*. *The driver for Uber, Lyft, taxi or other transportation does not qualify for the responsible party with the patient*. Please read Patient's Responsibilities Page 4.

If a responsible adult is not present the procedure will be cancelled.

Thank you for your cooperation and for following this requirement.

Valley View Surgery Center
1330 S. Valley View Blvd.
Las Vegas, NV 89102
Phone 702.675.4600

Patient Information Packet

Welcome to Valley View Surgery Center

The **Valley View Surgery Center** is a multi-specialty ambulatory surgery center. Our mission is to provide safe surgical care with competent physicians and staff members. We provide friendly, convenient and quality care to all our patients.

If your doctor has ordered pre-operative tests, (lab, EKG, or x-ray), please have your tests done at least 3 days prior to surgery.

You must have a driver and a responsible adult to accompany you home. If not, your procedure will be rescheduled. You cannot drive yourself home.

Driver for Uber, Lyft, taxi does not qualify as the responsible adult to accompany you home.

Your Doctor's office will provide you an ARRIVAL TIME: Your surgery/procedure will be approximately 45-1 hour after as we need time to get you ready and all prepped. Your family/driver may leave the facility if we have a contact number. When you are ready for discharge about 1 to 2 hours later, we will contact your driver, so they have time to get back to pick you up.

Important Insurance Information - Please Read

Your insurance company will be billed separately by your Surgeon and Anesthesiologist. You will receive a statement of your account from Valley View Surgery Center. You will also receive a bill/statement from Pathology if any was sent. If implants are used, they may be billed separately also. To discuss your bill or any concerns prior to your procedure, please feel contact Insurance Verification Dept. at 702-675-4604. ***Monday-Friday, 7:30 am - 4:00 pm.***

Remember to Bring on Date of Service

- Photo ID and Insurance card(s)
- Insurance Co-pays and deductibles are due on the date of service. We accept cash, check, credit cards and Care Credit.
- **Complete and bring with you, the attached forms:**
- Registration form
- Pre-Anesthesia Record
- Home Medication List
- Patient Acknowledgements
- If you have an Advance Directive – bring a copy.
- If you are the legal guardian of the patient being seen, documentation of guardianship will be **required** at registration.

Please leave all valuables at home, including jewelry

PREREGISTRATION IS ENCOURAGED

Please call 2 business days prior to your appointment.
702-675-4600 Monday - Friday
7a.m. -5p.m.

We are Located at 1330 S Valley View Blvd, Between Charleston Blvd and Oakey.

Valley View Surgery Center

Registration Form: Complete and bring this form with your ID and insurance card(s) to Register
Forma de Registracion: Completar y traer estas formas con su tarjeta de seguro(s) y identificación.

Patient Name Nombre de Paciente				**Date of Birth** Fecha de nacimiento	
S.S. #:		☐ **Male** Masculino ☐ **Female** Femenino Gender Identify/ Identificar género _____		**Marital Status** Estado civil	☐ S ☐ M / C ☐ W / V ☐ D
Race/Raza: ☐ American Indian/Indio Americano ☐ Alaska Native/Nativo de Alaska ☐ Asian/Asiano ☐ White/Blanco/a ☐ Black/African American/Afro Americano ☐ Other/Otro ☐ Decline to answer/Negar a contestar ☐ Native Hawaiian/Pacific Islander/Nativo Hawaiano/Isleño del Pacífico					
Address / Dirección City, State Zip Ciudad, Estado código postal					
Home Telephone Teléfono de casa				**Cell Phone** Teléfono de celular	
Employer Empleado				**Email** Correo electrónico	

Do you need language assistance, (i.e. translator, interpretor, sign). ☐ **No** ☐ **Yes, specify** _____
(If needed, this is available at no cost). Necesita un intérprete (Si es necesario, está disponible sin costo). ☐ No ☐ Si
Do you need other special assistance? ☐ **No** ☐ **Yes, specify** _____
Necesita ayuda adicional ? ☐ No ☐ Si, especificar _____

Primary Insurance / Seguro Primario

Insurance Co Nombre de seguro		**Telephone** Teléfono	
Insured Name Nombre del asegurado/a		**ID#**	
Patient's Relationship to Insured/Relación al paciente	☐ **Self /** Yo ☐ **Spouse /** Esposo/a ☐ **Child /** Hijo/a ☐ **Other /** Otro/a_____		
If insured is other than patient complete the following / Si asegurado/a no es el paciente por favor de completar lo siguiente			
S.S. #:	☐ **Male** Masculino ☐ **Female** Femenino	**Date of Birth** Fecha de nacimiento	
Employer Empleado			

Secondary Insurance / Seguro Secundario

Insurance Co Nombre de seguro		**Telephone** Teléfono	
Insured Name Nombre del asegurado/a		**ID#**	
Patient's Relationship to Insured/Relación al paciente	☐ **Self /** Yo ☐ **Spouse /** Esposo/a ☐ **Child /** Hijo/a ☐ **Other /** Otro/a_____		
If insured is other than patient, complete the following Si asegurado/a no es el paciente por favor de completar lo siguiente			
S.S. #:	☐ **Male** Masculino ☐ **Female** Femenino	**Date of Birth** Fecha de nacimiento	
Employer Empleador			

Valley View Surgery Center

Registration Form: Complete and bring this form and your ID & insurance card(s) to Register

Forma de Registracion: Completar y traer estas formas con su tarjeta de seguro(s) y identificación.

For Worker's Compensation Injury: Para lesiones/reclamo a compensación laboral:	
Claim/Caso #	
Date of Injury **Fecha de la lesión**	

Attorney's Name : Nombre de Abogado:	
Date of Injury **Fecha de Accidente**	
Address / City, StateZip Dirección /Ciudad, Estado, código postal	
Telephone Teléfono	

1. Have you taken any of the following medications: Ha tomado los medicamentos listados:		
Aspirin / Aspirina: ☐ Yes, date last taken Si, ultima fecha tomada	☐ No	
*Plavix/Clopidogrel: ☐ Yes, date last taken Si, ultima fecha tomado	☐ No	
*Coumadin/Warfarin: ☐ Yes, date last taken Si, ultima fecha tomado	☐ No	
Anti-inflammatory/Anti-Inflamatorio: ☐ Yes, date last taken Si, ultima fecha tomado	☐ No	
2. Female patients: Date of last menstrual period Para mujeres: Fecha de su ultima menstruación _____	☐ N/A	
3. List all surgeries (and when) / Lista de todas cirugías (con fechas) If additional, continue list on back / Continuar lista al reverso		
	YES/SI	NO
4. Asthma / Asma Shortness of breath/ Dificultad para respirar COPD	☐	☐
5. Do you smoke, how much per day: _____ Fuma, cuantos cigarrillos por día:	☐	☐
6. Any reaction to latex products / Cualquier reacción a los productos de látex	☐	☐
7. Heart attack — Ataque de Corazon Palpitations — Palpitaciones High blood pressure — Alta presión Heart Valve problems — Prolapso de la válvula cardiacas	☐	☐
8. Pacemaker / Marcapasos	☐	☐
9. TMJ (dysfunction of temporomandibular joint)/ TMJ (disfunción de la articulación temporomadibular)	☐	☐
10. Stroke / Derrame Cerebral Seizures / Convulsiones Blackouts / Desmayos	☐	☐
11. Parkinson disease / Enfermedad de Parkinsons Dementia / Demencia	☐	☐
12. Hiatal Hernia / Hernia Hiatal Ulcers / Ulceras	☐	☐
13. Hepatitis If yes / Encaso que si que tipo Type : ☐ A ☐ B ☐ C	☐	☐
14. Do you drink alcohol, how much: _____ Last time: _____ Consume bebidas alcolicas, en caso que si, cantidad_____ Ultima vez: _____	☐	☐
15. Diabetes / Diabetes Type: / Tipo:	☐	☐
16. Thyroid Problems / Problemas de la Tiroides	☐	☐
17. Previous Colonoscopy / Colonsocopia anterior If Yes, when: _____En caso que si cuando:_____	☐	☐
18. Back / Neck Problems Problemas de espalda / cuello	☐	☐
19. Anxiety / Ansiedad	☐	☐
20. Muscle Diseases / Enfermedad Muscular	☐	☐
21. Sleep Apnea / Apnea del sueño If yes, do you use/En caso que si, usas : BIPAP ☐ CPAP ☐ None/Ninguno ☐	☐	☐
22. Blood Transfusion / Transfusión de sangre Hemophilia / Hemofilia Sickle cell Anemi / Anemia falciforme	☐	☐
23. Kidney Disease / Enfermedad renal Dialysis patient / Paciente de diálisis If yes, date of last dialysis: _____ En caso que si, fecha de ultimo tratamiento:	☐	☐
24. HIV Positive / VIH Positivo	☐	☐
25. Metal Implants / Inplantes Metálicos	☐	☐
26. Cancer. If yes, where:_____ Cancer, en caso que si, en donde:_____	☐	☐
27. Long term antibiotic treatment Tratamiento de antibioticos a largo plazo	☐	☐
28. Do you use marijuana, last date: _____ Utilizas marijuana, ultima vez:_____	☐	☐
29. Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery Usted o su familiar a tenido fiebre inexplicable durante o despues de cirugia	☐	☐
30. Have you traveled outside of country in the past 6 months / Has viajado afuera del país en los últimos 6 meses	☐	☐
31. Any additional information to communicate, may continue on reverse / Cualquier información adicional paracomunicarse, puede continuar al reverso:	☐	☐
Nursing Comments:		

_____

Patient Signature / Firma de paciente

☐ Returning within 30 days. There are no changes to my answers for questions # 3-31.

He revisado mis respuestas a las preguntas # 3-31, y en los ultimos 30 dias, no a habido ningún cambio.

_____

Signature of Pre Op Nurse — Date

* ☐ = Fall risk

Valley View Surgery Center

Pre-Anesthesia Record

Patient Label

Valley View Surgery Center

PATIENT HOME MEDICATION LIST / LISTA DE MEDICAMENTOS

Please fill in highlighted areas only and bring form back to VVSC before or on the day of your procedure. Comp ete areas resaltadas y traiga a VVSC antes o el dia del procedimiento.

□ No Known Allergies/Sin alergias conocidas. **ALLERGIES AND THEIR REACTIONS/ALERGIAS Y REACCIONES:**

List all medications taken over the past 6 months (include prescriptions, over the counter, vitamins, herbal supplements, medications via patch, birth control treatment).
Anote todos los medicamentos que ha tomado durante los ultimos 6 meses, (incluye medicamentos recetados, de venta libre, vitaminas, suplementos, parches, anticonceptivos).

Medication Name/ Nombre de Medicina	Dose/Dosis	Frequency (How often?) Frecuencia	Reason for Taking/Razon para Tomar	Date of Visit: _____ Last Taken (Date/Time)	Date of Visit: _____ Last Taken (Date/Time)	Date of Visit: _____ Last Taken (Date/Time)	Date of Visit: _____ Last Taken (Date/Time)

New Prescriptions (Completed by Nurse)	Dose	Frequency (How often?)	Reason for Taking	□**New Rx given to pt. Copy in MR	□**New Rx given to pt. Copy in MR	□**New Rx given to pt. Copy in MR	□**New Rx given to pt. Copy in MR
∞Pre-Op Nurse Signature *Complete Medication Information Unknown by pt. = CMI Unk				∞ *□CMI Unk	∞ *□CMI Unk	∞ *□CMI Unk	∞ *□CMI Unk
¥ is PACU Nurse Signature □ Instructed pt.to resume medications as instructed/ordered by M.D. ** □Check box if pt./cg instructed on medication use, common side effect, and aftercare upon discharge for new Rx.				**□ ¥ □Copy of med list given to pt. on DC.	**□ ¥ □Copy of med list given to pt. on DC	**□ ¥ □Copy of med list given to pt. on DC	**□ ¥ □Copy of med list given to pt. on DC

******** Contact your prescribing physician for questions regarding any medications listed on this page********

PATIENT LABEL | PATIENT LABEL | PATIENT LABEL | PATIENT LABEL

Patient Acknowledgements / Reconocimiento del Paciente

Next of Kin / *Pariente Próximo:*

Name/*Nombre*: _____ Relationship/*Relación*: _____

Address and/or telephone number/*Domicilio y/o numero de teléfono*: _____

In Case of Emergency, I authorize VVSC to Contact / *En caso de Emergencia, yo autorizo a VVSC contactar a:*

Name/*Nombre*: _____ Relationship/*Relación*: _____

Address and/or telephone number/*Domicilio y/o numero de teléfono*: _____

I authorize VVSC staff to discuss my medical care with / ***Yo autorizo al personal de VVSC para discutir mi cuidado médico con:***

Name of person(s) / *Nombre de persona(s)*: _____

Advanced Directive / ***Directivas Anticipadas:*** **(not applicable for patients under 18 years of age** / ***no es aplicable a pacientes menores de 18 años*****)**

Information regarding Advanced Directives is included in the Patient Information Packet / *La Información sobre Directivas Anticipadas esta incluida en su paquete de información:*

☐ **I do** have an advanced directive / ***Si tengo*** *una Directiva Anticipada;*

- A copy is provided to VVSC: **Yes** **No** / *Se proporciona una copia a VVSC:* ***Si*** ***No***
- I understand that it is my responsibility to inform my physicians of my Advance Directive / *Yo entiendo que es mi responsabilidad informar a mis médicos de mi Directiva Anticipada.*

☐ **I do not** have an advanced directive / ***Yo no*** *tengo una Directiva Anticipada*

Acknowledgement of receipt of Patient Information Packet / *Reconocimiento de paquete de Información de Paciente:*

As required by CMS (Centers for Medicare and Medicaid Service), written and verbal notice regarding Patients Rights and Responsibilities, Advance Directives and the facility's corresponding Policy, and a list of VVSC business owners is given to patients. Signature below acknowledges receipt of the written and verbal notice. / *Segun los requisitos de CMS (Centros de Servicios de Medicare y Medicaid), por escrito y la notificación en verbal sobre los Derechos y Responsabilidades de los Pacientes, Directivas Anticipadas y la politica correspondiente de la instalación, y una lista de los dueños del negocio de VVSC se da a los pacientes. La firma debajo confirma que la recibí por escrito y verbal.*

☐ Received this date / *Recibido esta fecha*

☐ Received with previous date of service / *Recibido con fecha anterior del servicio*

X_____ Date / *Fecha*: _____

Patient or Representative signature (if other than patient, relationship:_____).
Firma de Paciente o Representante (si no es paciente, que es relación)

Valley View Surgery Center
Patient Acknowledgements

Patient label