NAME: _____ **DATE:** _____

REASON FOR VISIT: _____

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ **NO MEDICAL HISTORY**

Constitutional:
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Loss of Appetite

Neurological:
- ☐ Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Fainting Spells
- ☐ Seizure Disorder

Cardiovascular:
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Status Post CABG
- ☐ Deep Vein Thrombosis
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Aortic Aneurysm
- ☐ Rheumatic Fever
- ☐ Aortic Valve Replacement
- ☐ Mitral Valve Replacement
- ☐ Heart Problems
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Ankles

Pulmonary:
- ☐ Chronic Cough
- ☐ COPD
- ☐ Coughing Up Blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea

Gastrointestinal:
- ☐ Poor Appetite
- ☐ Black Stool
- ☐ Regurgitation
- ☐ Vomiting
- ☐ Vomiting with Blood
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ GERD
- ☐ Nausea
- ☐ Bloating
- ☐ Burping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Rectal Bleeding
- ☐ Rectal Itching
- ☐ Rectal Pain
- ☐ Abdominal Pain
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Genitourinary:
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Disease
- ☐ Kidney Stones

Endocrine:
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Pre-Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Musculoskeletal:
- ☐ Joint Pain
- ☐ Arthritis
- ☐ Muscle Pain
- ☐ Fibromyalgia
- ☐ Myopathy
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Leg Cramps
- ☐ Lower Back Pain
- ☐ Gout

Hematological:
- ☐ Anemia
- ☐ Blood Disorder
- ☐ AIDS
- ☐ HIV
- ☐ Blood Transfusion
- ☐ Anticoagulant Treatment

Integumentary:
- ☐ Rashes
- ☐ Skin Disease
- ☐ Changes in Nail Color
- ☐ Herpes
- ☐ Skin Cancer

Psychiatric:
- ☐ Memory Loss
- ☐ Hallucinations
- ☐ Bipolar
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Stress
- ☐ Sleep Disturbances

Have you had cancer? _____ If YES, what type of cancer? _____

SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

- ☐ Appendectomy
- ☐ Bowel Resection
- ☐ Colostomy
- ☐ Colectomy
- ☐ Gallbladder removal
- ☐ Open Heart Surgery
- ☐ C-Section
- ☐ Eye Surgery
- ☐ Pacemaker Implant
- ☐ Hernia Repair
- ☐ Complete Hysterectomy
- ☐ Partial Hysterectomy
- ☐ Hepatobiliary Surgery
- ☐ Kidney transplant
- ☐ Stent Placement
- ☐ Liver Transplant
- ☐ Sterilization
- ☐ Gastric Bypass
- ☐ Gastric Sleeve

OTHER: _____

MEDICATION: (Please list all current medications with dosage and frequency)

☐ **NOT TAKING ANY MEDICATION**

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: (Please check all that apply and include all known allergies) ☑

☐ **NO KNOWN DRUG ALLERGIES**
☐ SULFA
☐ PENICILLIN
☐ ASPIRIN
☐ CODEINE
☐ IV DYE
☐ IODINE
☐ OTHER: _____
_____
_____
_____
_____

ARE YOU TAKING ANY OF THESE MEDICATIONS?

☐ **YES** ☐ **NO, I do not take any of these medications**

IF YES, please check which one:

☐ **OZEMPIC**	☐ **TRULLICITY**	☐ **SAXENDA**	☐ **BYDUREON BCise**
☐ **SEMAGLUTIDE**	☐ **DULAGLUTIDE**	☐ **URAGLUTIDE**	☐ **EXENATIDE**
☐ **RYBELSUS**	☐ **VICTOZA**	☐ **BYETTA**	☐ **MOUNJARO**
☐ **WEGOVY**	☐ **LIRAGLUTIDE**	☐ **EXENATIDE**	☐ **TIRZEPATIDE**

Have you ever had a colonoscopy? _____

If yes, when was your last colonoscopy? _____

Have you recently been admitted to the hospital? _____

If yes, what hospital? _____

What is the approximate date and reason? _____

Do you have any **siblings**? ☐ YES ☐ NO Are they healthy? ☐ YES ☐ NO

How many brothers? _____ How many sisters? _____

Do you have any **children**? ☐ YES ☐ NO Are they healthy? ☐ YES ☐ NO

How many sons? _____ How many daughters? _____

SOCIAL HISTORY: (Please check all that apply)

Do you smoke? ☐ **YES** ☐ **No, never smoked** ☐ **No, former smoker**

If you are a former smoker, when did you quit smoking? _____

How often do you smoke? ☐ EVERDAY ☐ SOMEDAYS

How soon after waking up do you smoke?
- ☐ Within 5 mins
- ☐ 6-30 mins
- ☐ 31-60 mins
- ☐ after 60 mins

How many cigarettes a day?
- ☐ 5 or less
- ☐ 6-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 or more

Are you interested in quitting? ☐ READY ☐ Not Ready ☐ Thinking about quitting

Are you pregnant?
- ☐ **No**
- ☐ **Yes, weeks? _____ weeks**

Recreational Drug Use:
- ☐ **No**
- ☐ **Yes, what type: _____**

Do you have tattoos?
- ☐ **No**
- ☐ **Yes**

Do you drink alcohol?
- ☐ **No**
- ☐ **Yes**

IF YOU DRINK ALCOHOL, PLEASE CONTINUE:

How often did you have a drink containing alcohol in the past year?
- ☐ Never
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?
- ☐ 1-2 Drinks
- ☐ 3-4 Drinks
- ☐ 5-6 Drinks
- ☐ 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?
- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

FAMILY HISTORY

Has anyone in your family suffered from cancer?

☐ **YES** ☐ **UNKNOWN** ☐ **No one in my family has suffered from cancer**

Type of Cancer:	**PLEASE CIRCLE ONE**	**AGE**
FATHER: _____	ALIVE / DECEASED	_____
MOTHER: _____	ALIVE / DECEASED	_____
SISTER: _____	ALIVE / DECEASED	_____
BROTHER: _____	ALIVE / DECEASED	_____
Grandfather: _____	ALIVE / DECEASED	_____
Grandmother: _____	ALIVE / DECEASED	_____
UNCLE: _____	ALIVE / DECEASED	_____
AUNT: _____	ALIVE / DECEASED	_____
Other relatives: _____	ALIVE / DECEASED	_____

PLEASE CHECK YOUR PROVIDER:

☐ **Enrique J. Lacayo MD LTD**
PHONE: (702) 382-6970
Fax: (702) 382-9493

☐ **Yakov D Shaposhnikov MD PC**
Phone: (702) 737-3337
FAX: (702) 737-4307

SCHEDULING LINE: (702) 527-7900

PATIENT REGISTRATION

Last Name: _____ **First Name:** _____ **MI**: _____

Date of birth: _____ **SSN:** _____ Preferred Language: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ **CELL:** _____

Pharmacy Name/Phone/Address: _____

Responsible Party/Guardian: _____ Guardian's Date of birth: _____ ☐ **SELF**

Marital Status: ☐Divorced ☐Married ☐Partner ☐Single ☐Decline

Gender Identity: ☐Male ☐Female ☐Genderqueer ☐Choose not to disclose
☐Female TO Male ☐Male TO Female ☐OTHER: _____

Email Address: _____

Referring Doctor's Name: _____

Primary Care Physician Name: _____

Are you employed? ☐**YES** ☐**NO** **Employer:** _____
☐Full-time ☐Part-time ☐Student ☐Unemployed ☐Retired

Occupation: _____ Work number: _____

EMERGENCY CONTACT NAME: _____

Contact Phone: _____ Relationship to Contact: _____

Race: *Please mark what best describes you*

☐ I prefer not to answer	☐ Samoan	☐ Japanese	☐ Vietnamese
☐ White/Caucasian	☐ Black/African American	☐ American Indian/Alaskan	☐ Other Pacific Islander
☐ Chinese	☐ Filipino	☐ Asian Indian	☐ Other race
☐ Native Hawaiian	☐ Guamanian or Chamorro	☐ Korean	

Ethnicity: *Please mark what best describes you*

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I prefer not to answer

INSURANCE INFORMATION

☐ **No Insurance**

PRIMARY INSURANCE

Insurance Name: _____ Relationship to Policy Holder: _____

Policy Holder Name: _____ Policy Holder DOB: _____ Sex: _____

Member ID Number: _____ Group #: _____

Claim's Address: _____ Phone: _____

SECONDARY INSURANCE

Insurance Name: _____ Relationship to Policy Holder: _____

Policy Holder Name: _____ Policy Holder DOB: _____ Sex: _____

Member ID Number: _____ Group #: _____

Claim's Address: _____ Phone: _____

This pertains to your primary, secondary and/or tertiary insurance.

Our office will file insurance claims for all reimbursable services with the patient's primary and secondary insurance carriers. However, the patient is responsible for all deductible amounts, copayments, and fees for non-covered services. All professional services rendered will be billed to the patient directly. The patient is responsible for all fees, regardless of insurance coverage.

If a patient chooses to see an out-of-network provider, they understand that this may result in higher out-of-pocket costs if their insurance plan allows for out-of-network services. If the insurance does not cover out-of-network services, the patient will be responsible for the entire balance.

In the event of collection proceedings due to non-payment, the patient or guarantor agrees to pay all collection fees that may be added to their account to recover amounts owed to Dr. Enrique Lacayo or Dr. Yakov Shaposhnikov.

If a patient fails to show up for an appointment without prior notice, there will be a charge of $25.00 for office visits and $75.00 for procedure visits if canceled less than 48 hours in advance, unless in the case of emergencies. In instances of multiple no-shows or cancellations, Dr. Enrique Lacayo and Dr. Yakov Shaposhnikov reserve the right to refuse further service.

The undersigned guarantees full payment. The guarantor understands that all patients, including those with Medicare or other insurance, are personally responsible for any balance remaining after the insurance company has made its payment.

I hereby assign and direct payment for any procedure, surgical, or medical benefits under claims submitted directly to Dr. Enrique Lacayo or Dr. Yakov Shaposhnikov. I also authorize the release of any medical records or information requested by insurance companies in connection with these assignments. I understand that my doctor has no obligation to provide consults, narrative reports, or depositions to my attorney. Additionally, I understand that under no circumstances will my doctor testify in court on my behalf.

_____ _____

SIGNATURE of Patient or Responsible Party **DATE**

_____ _____

PRINT NAME RELATIONSHIP to Patient

CONSENT TO TREAT

I have the legal right to consent to medical and surgical treatment because (a) I am the patient, or (b) I am the parent or guardian of the patient. For the purposes of this document, "patient," "me," and "my" refer to:
Patient's Name: **Date of Birth:**

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Dr. Enrique Lacayo, Dr. Yakov Shaposhnikov, and their designated associates or assistants deem necessary. I also consent to the taking of photographs or videos related to the care and treatment of the patient, and I understand that such photographs or videos may become part of the patient's medical record.

I understand that by signing this form, I am granting permission to the doctors, nurses, physician assistants, nurse practitioners, and other healthcare providers in this medical office to provide treatment, as long as a physician-patient relationship exists, or until I withdraw my consent.

_____(PLEASE INITIAL)

Sharing Records for Treatment

We share medical records with other healthcare providers to ensure continuity of care. If you visit another provider, they may have access to your medical records.

_____(PLEASE INITIAL)

Acknowledgment of Financial Policy

I acknowledge that I have received the Financial Policy from Dr. Yakov Shaposhnikov and Dr. Enrique Lacayo. This policy outlines my financial responsibilities and explains how any past due balances will be managed. If you have any questions, please feel free to contact our manager at (702) 527-7907. A copy of the policy is available at the front desk.

_____(PLEASE INITIAL)

Acknowledgment: Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices from Dr. Enrique Lacayo and Dr. Yakov Shaposhnikov. This Notice explains how our office may use and disclose the patient's protected health information for purposes related to treatment, payment, and health care operations. "Protected health information" refers to the patient's personal health information found in their medical and billing records.

_____(PLEASE INITIAL)

Acknowledgment of Office Information & Policies

I confirm that I have received the Office Information and Policies of Dr. Yakov Shaposhnikov and Dr. Enrique Lacayo. By doing so, I agree to abide by the policies outlined. I have either read this form or it has been read to me in a language I understand, and I have had the opportunity to ask any questions regarding its content.

_____(PLEASE INITIAL)

_____ _____

SIGNATURE of Patient or Responsible Party **DATE**

_____ _____

PRINT NAME RELATIONSHIP to Patient

REQUEST FOR MEDICAL RECORDS

Do you permit our staff, along with Dr. Enrique Lacayo and Dr. Yakov Shaposhnikov, to request your medical records from other providers and facilities? (This will enable the doctors to gain a better understanding of your health, allowing them to provide you with the best possible care.)

- ☐ I **ALLOW** my information to be transmitted by fax. I understand that this may limit the security or confidentiality of my records.
- ☐ I **DO NOT ALLOW** my information to be transmitted by fax.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION.

I understand that giving permission for the disclosure of my health information is voluntary, and I have the right to refuse to sign this authorization. I do not need to sign this form in order to receive treatment. I am aware that I can review or request a copy of the information that will be used or disclosed, as stated in CFR 164.524. If I have any questions about this disclosure of my health information, I can contact the office to obtain a copy of the privacy notice.

_____ _____

SIGNATURE of Patient or Responsible Party **DATE**

DURATION: Authorization shall be effective immediately and remain in effect for one year.

REVOCATION: Written revocation will be effective upon receipt.

AUTHORIZATION FOR MESSAGES

I authorize this office to leave detailed messages on the answering service and/or voicemail: (please check all that apply)

- ☐ HOME
- ☐ CELL
- ☐ I DO NOT AUTHORIZE (DO NOT CALL ME)

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION:

Your medical information is private and important. We will only discuss your medical condition with the person you designate. Would you like to designate a family member or another individual with whom we can share your medical information? ☐ NO ☐ YES

First and Last Name	Relationship	Phone Number
First and Last Name	Relationship	Phone Number
First and Last Name	Relationship	Phone Number
First and Last Name	Relationship	Phone Number

I hereby authorize the following individual(s) to participate in discussions regarding my complete health record. I understand that this may include information about my medical, surgical, and psychiatric treatments, as well as drug treatment, HIV/AIDS testing, and counseling.

I release Dr. Enrique Lacayo, Dr. Yakov Shaposhnikov, and all office staff from any costs, liabilities, or damages that may arise, either directly or indirectly, from the release of my medical records.

_____ _____

SIGNATURE of Patient or Responsible Party **DATE**

_____ _____

PRINT NAME RELATIONSHIP to Patient