TOTAL SPORTS MEDICINE & ORTHOPEDICS

Joseph Yu, MD
10105 Banburry Cross Dr,
Suite 445 Las Vegas, NV 89144

Phone: (702) 475-4390
Fax: 888-634-8658
Email: info@dryu.com

PATIENT INFORMATION

Patient Name		☐ DR	☐ MR	☐ MRS	☑ MS		
City		State		Zip			
Phone		Email					
Address							
Do you have an Advanced Directive/Living will?		☑ Yes	☐ No				
Were you in a motor vehicle accident?		☐ Yes	☐ No				
Was it on the job?		☐ Yes	☐ No				
Are you currently employed? ☐ Yes ☐ No		**If yes, Occupation?**					

PHARMACY

Pharmacy Name	
Address	

EMERGENCY CONTACT

Name		Phone	
Relationship to patient			

PRIMARY INSURANCE INFO (must be completed even if cards provided)

Primary Insurance		Subscriber DOB	
Primary Insurance Subscriber		Member ID	
Group		Relationship to patient	

SECONDARY INSURANCE INFO (must be completed even if cards provided)

Primary Insurance		Subscriber DOB	
Primary Insurance Subscriber		Member ID	
Group		Relationship to patient	
Patient Name		Date of Birth	

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FINANCIAL POLICY

Payment for medical services rendered is due at the time of service, unless prior arrangements have been made.

We verify eligibility and benefits with your insurance, but if we can't confirm your status, you'll be required to pay for services until we do. The patient's portion, including copayments, is due at the time of service. We will assist with insurance claims, but you are ultimately responsible for payment. If you're scheduled for surgery, a deposit may be required before the surgery date. Prior authorizations are not a guarantee of payment and claims are subject to your insurance's terms. If your account becomes delinquent, it will be sent to collections.

By signing, you agree to pay all charges, legal fees, and a $25 fee for returned checks. Unresolved returned checks will be sent to the Clark County District Attorney's office. You also authorize your insurance or other payer to pay Orthopedic Solutions, LLC directly for services rendered. You are responsible for all charges, whether you have insurance or not. A photocopy of this agreement is as valid as the original.

There is a $75 fee for FMLA or Disability forms, which covers 6 months of revisions.

Prescription Drug Policy

Starting November 1, 2015, new DEA regulations require stricter prescription drug rules in our office. Narcotic pain medications can no longer be called into the pharmacy and will only be prescribed for fractures, surgery recovery, or other serious injuries. We do not treat chronic pain. Narcotic prescriptions will not be refilled more than 8 weeks after your injury or surgery. If pain persists, we will refer you to a pain management specialist.

You cannot get narcotics from multiple doctors; the DEA tracks prescriptions and the pharmacy will not fill a second prescription. All prescriptions require an office visit for documentation. If you need a prescription, you must schedule an appointment. If the physician is unavailable, please see your primary care doctor, another doctor, or visit Urgent Care or the Emergency Room. Plan ahead if you're running low on a prescription.

Signature _____ Date _____

Name (Patient/Guardian)	
SSN of Patient (If minor, parent/guardian ssn)	

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Office Use Only

INS		DOB	
CHART #		TIME IN	

Patient Name					
Age		Height		Weight	
What body part bothers you?	☐ Right	☐ Left			
When did it start?					

Describe the problem: Rate the Pain 1-10 (10 being the worst):

Have you obtained any prior treatments: (Physical Therapy, Surgery, MRI/XRAY, etc)

Check all that apply for the pain:

☐ Constant	☐ Intermittent (pain starts and stops at different times)
☐ Dull/Sharp (circle which one)	☐ Tingling

Select all the ways in which the pain impacts you:

☐ Instability	☐ Stiffness	☐ Weakness
☐ Numbness in the area	☐ Pain wakes you up at night	☐ Worst with
☐ Sitting/Standing/Bending	☐ Lifting/Overhead Activities	☐ Reaching
☐ Other:		

ALLERGIES: Please list all of your current medication allergies

Medication		Reaction	
Medication		Reaction	
Medication		Reaction	
Medication		Reaction	

MEDICATION: Please list all medications you are taking. (If separate list is available, let a staff member know)

Medication		Medication	
Medication		Medication	
Medication		Medication	
Medication		Medication	

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SURGICAL HISTORY: Please list all of the surgical procedures you've received

Procedure		Date (Month and Year)	
Procedure		Date (Month and Year)	
Procedure		Date (Month and Year)	
Procedure		Date (Month and Year)	

SOCIAL HISTORY

Ethnicity			Languages	
Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widow
Do you smoke?	☐ Yes	☐ No	**If yes, how long?**	
Do you use recreational drugs?	☐ Yes	☐ No	**Specify:**	
Do you drink alcohol?	☐ Yes	☐ No	**If yes, how long?**	

FAMILY HISTORY

Mother	☐ Living	☐ Deceased
Medical Issues?		
Father	☐ Living	☐ Deceased
Medical Issues?		

MEDICAL HISTORY

Check all that apply:

Constitutional		
☐ Fever/Chills	☐ Weight gain/loss	☐ Fatigue
☐ Excessive/Lack of sleep		
Heart		
☐ High Blood Pressure	☐ High Cholesterol	☐ Coronary Artery Disease
☐ Heart Attack	☐ Congestive Heart Failure	☐ Arrhythmias
☐ Chest pain	☐ Irregular heartbeat	☐ Leg swelling

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Lung

☐ Asthma	☐ COPD	☐ Sleep Apnea
☐ Shortness of breath	☐ Wheezing	

Arrhythmias

☐ Chest pain	☐ Irregular heartbeat	☐ Leg swelling

Gastrointestinal

☐ GERD	☐ Peptic Ulcer

Hematology

☐ Blood Clots	☐ Bleeding Disorder	☐ Cancer
☐ Easy bruising/bleeding	☐ Anemia	☐ Prior transfusion:

Infectious

☐ Seasonal allergies	☐ Hay fever symptoms	☐ HIV
☐ **Hepatitis**	☐ A ☐ B ☐ C ☐ D	

Endocrine

☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Heat/cold intolerance
☐ **Diabetes**	☐ Type I	☐ Type II

ENT

☐ Diculty with hearing	☐ Ear pain	☐ Runny nose
☐ Mouth sores	☐ Sore throat	

Ophthalmology

☐ Vision changes	☐ Blurred vision	☐ Double vision

Neurological

☐ Dizziness	☐ Memory loss	☐ Headache
☐ Seizures	☐ Problems with balance	

Nephrology

☐ Urinary incontinence	☐ Urinary retention	☐ Urinary frequency
☐ Burning	☐ Kidney Failure	

Psychiatric Problems

☐ Anxiety	☐ Depression	☐ Hallucination

Integumentary

☐ Rash	☐ Hair loss	☐ Skin lesion
☐ Dry skin		

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HIPAA Notice Of Privacy Practices

Authorization for Use and Disclosure of Health Information

I, _____, authorize Total Sports Medicine and Orthopedics to:

Obtain the following protected health information **FROM**: _____

Disclose the following protected health information **TO**: _____

Provider			
Address			
Phone		Fax	

Health records include my health history, symptoms, exams, test results, diagnoses, and treatment plans. This information will be used for:

1. Planning my care and treatment
2. Communicating among healthcare professionals
3. Billing purposes
4. Verifying services provided for third-party payers

I authorize the following person to access my healthcare information:

Name		Relationship	

This authorization expires two years from the date of signature. I have received a Notice of Privacy Practices describing information uses and disclosures. I understand I can revoke this authorization in writing at any time, and that once disclosed, my information may no longer be protected by federal privacy laws.

Notice of Privacy Practices:

Refusing to sign will not affect your ability to receive treatment, payment, or benefits. You may inspect or copy the information being disclosed. Please send my health information to:

Total Sports Medicine, 10105 Banburry Cross Dr. Ste. 445, Las Vegas, NV 89144

Patient's Signature _____ Date Signed _____ Date of Birth _____

SUBMIT