TOTAL SPORTS MEDICINE & ORTHOPEDICS

PATIENT INFORMATION

Date:______________ Patient Name:_______________________________________ ❑Dr. ❑Mr. ❑Mrs. ❑Ms.
Date of Birth:_____________________ SSN:____ (required for billing)
Address:____ City/State/Zip:________________________________
Phone:__________________________ Email:____

Best contact (check all that apply): ❑Call ❑Email ❑Text

Do you have an Advanced Directive/Living Will ❑No ❑Yes If **YES**, please provide a copy or any information:

____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY INFORMATION

Responsible Party Name:____ ❑Dr. ❑Mr. ❑Mrs. ❑Ms.
Date of Birth:_____________________ SSN:____ (required for billing)
Address:____ City/State/Zip:________________________________
Phone:__________________________ Email:____

Best contact (check all that apply): ❑Call ❑Email ❑Text

EMERGENCY CONTACT Name:_____________________________________Phone:_________________________
Relationship to patient:____

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

Primary Insurance:____
Primary Insurance Subscriber:_________________________________Subscriber Date of Birth:________________
Member ID:_________________________Group#________________Relationship to patient:_________________

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

Primary Insurance:____
Primary Insurance Subscriber:_________________________________Subscriber Date of Birth:________________
Member ID:_________________________Group#________________Relationship to patient:_________________

WORKER COMPENSATION INFORMATION

Were you injured on the job? ❑ No or ❑ Yes If **YES**, date of Injury: _____________________________________

MOTOR VEHICLE ACCIDENT INFORMATION

Were you injured in a motor vehicle accident? ❑ No or ❑ Yes If **YES**, date of Injury: ______________________

I hereby sign to Dr. Joseph Yu, Dr. William R. McGee, and Van Nguyen PA-C all benefits for medical and surgical care payable under the policies of the practice. I also authorize the release of information under the same policy. I understand that I am financially responsible for any changes not covered by my insurance.

____________________________________ ________________________________ ________________________
Print Name (Parent, if minor) Signature Date

TOTAL SPORTS MEDICINE & ORTHOPEDICS

PATIENT HISTORY (1 of 4 pages)

Patient Name:_______________ Age:____ Height:___ft___in Weight:______lbs
Primary Care Doctor Name:_______________ Pharmacy Name:_______________
Primary Care Phone:_______________ Pharmacy Address/Phone:_______________
Who referred you:_______________

Did you have any previous imaging done related to the evaluation today within the past 6 months? ❑No ❑Yes

If **YES**, what type? ❑X-ray ❑MRI ❑CT ❑Other:_______________
Where was the exam done? (List facility name, phone or location):_______________

How did you find us? ❑Friend/Family ❑Yelp ❑Facebook ❑Google ❑Other:_______________

ATHLETES

School:_______________ Sport(s):_______________
Head Coach:_______________ Position Coach:_______________
Athletic Trainer:_______________ Phone#:_______________

ALLERGIES

Medication:_______________ Reaction(s):_______________
Medication:_______________ Reaction(s):_______________

Non-Medication Allergies: ❑Metals ❑Iodine ❑Injections ❑Latex ❑IV Dye ❑Other:_______________
____

MEDICATIONS- Please list all medications you are taking (If separate list available, a copy will be kept on file).
Medication name, dose, frequency and reason

Medication:_______________ Reason:_______________
Medication:_______________ Reason:_______________
Medication:_______________ Reason:_______________
Medication:_______________ Reason:_______________

MEDICAL HISTORY- Please check all that apply.

Common
- ❑High Blood Pressure
- ❑High Cholesterol
- ❑Hypothyroidism
- ❑Diabetes

Psychiatric Problems
- ❑Anxiety
- ❑Depression

Lungs
- ❑Asthma
- ❑Emphysema
- ❑Sleep Apnea

Stomach
- ❑Reflux Disease
- ❑Ulcer
- ❑Colitis

Brain
- ❑Seizures
- ❑History of Stroke

Heart
- ❑Coronary Artery Disease
- ❑Heart Attack
- ❑Congestive Heart Failure
- ❑Irregular Heart Beat

Blood
- ❑Blood Clots
- ❑Bleeding Disorder
- ❑HIV

Liver
- ❑Hepatitis ❑A ❑B ❑C
- ❑Kidney Problems
- ❑Cancer:_______________

Joint
- ❑Arthritis
- ❑Rheumatoid Arthritis
- ❑Reflex Sympathetic Dystrophy

❑Other:_______________
____
____

TOTAL SPORTS MEDICINE & ORTHOPEDICS

PATIENT HISTORY Cont... (2 of 4 pages)

Patient Name: ____________________ Date of Birth: ____________

What BODY PART(S) and SIDE will be evaluated today?

Check **BELOW** all that apply and **CIRCLE** the associated side of body part R/L/B (Right/Left/Both).

Upper Extremity: ❑Shoulder R/L/B ❑Elbow R/L/B ❑Wrist R/L/B ❑Hand R/L/B

Lower Extremity: ❑Hip R/L/B ❑Knee R/L/B ❑Shin R/L/B ❑Ankle R/L/B ❑Foot R/L/B

Head/Back (Spine): ❑Head ❑Neck (Cervical) ❑Mid (Thoracic) ❑Lower (Lumbar)

Other R/L/B: ____________________

What is the problem? ❑Pain ❑Instability ❑Stiffness ❑Swelling ❑Other: ____________

What is the approximate DATE the problem begin? ____________ How did it start? ____________

Where do you feel the pain? ____________________

What is the nature of the pain? ❑Dull ❑Sharp ❑Burn ❑Other: ____________

Does the pain radiate? ❑No ❑Yes If **YES**, where? ❑Back ❑Hip ❑Thigh ❑Knee ❑Foot ❑Arm ❑Neck

❑Hand ❑Other: ____________________

What makes the pain worse? ❑Sitting ❑Standing ❑Walking ❑Stairs ❑Bending ❑Overhead Activities

❑Lifting ❑Reaching back ❑Other: ____________________

What are you doing when there is pain? ____________________

How often do you have the pain? ❑Constantly ❑Only with certain activities ❑Other: ____________

Is there any of the following? ❑Stiffness ❑Numbness ❑Instability ❑Weakness ❑Pain wakes you up at night

What are some things that you can't do anymore (because of the pain)? ____________________

Are you currently working? ❑No ❑Yes

Do you use assistive devices: ❑No ❑Yes If **YES**, what do you use? ❑Brace ❑Cane ❑Crutches ❑Walker

❑Wheelchair ❑Other: ____________________

Is your walking distance limited by the pain? ❑No ❑Yes If **YES**, estimate your **MAXIMUM** walking distance:

❑Less than a block ❑1-2 ❑3-6 ❑>6

Have you seen any other doctor for this problem? ❑No ❑Yes If **YES**, please list: ____________

Have you had surgery in the area you are having pain? ❑No ❑Yes If **YES**, do you have any info (Name of procedure, specialty or surgeon): ____________________

Have you had steroid (ie: cortisone) injections to the area you have pain before? ❑No ❑Yes If **YES**, did it help?

❑No ❑Yes If **YES**, did it help? ❑No ❑Yes If **YES**, for how long? ___ ❑Weeks ❑Months

When was the last injection (last approximate date)? ____________

If your knees are being treated, have you had had viscosupplementation (gel or lubricant) injections before?

❑No ❑Yes If **YES**, did it help? ❑No ❑Yes If **YES**, for how long? ___ ❑Weeks ❑Months

When was the last injection (last approximate date)? ____________

Had physical therapy? ❑No ❑Yes If **YES**, where (Facility Info)? ____________________

How many weeks? ______ Did it help? ❑No ❑Yes

Did you take medications to relieve the pain? ❑No ❑Yes if **YES**, please list all below:

Name: ____________________ Pills per day: ____________

TOTAL SPORTS MEDICINE & ORTHOPEDICS

PATIENT HISTORY Cont... (3 of 4 pages)

Patient Name: ______________________ Date of Birth: ______________

SURGICAL HISTORY- Please list surgeries, to include specific body part if possible and date of surgery.

❑Tonsillectomy:__________ ❑Coronary Artery Bypass:__________ ❑Breast Cancer:__________

❑Appendectomy:__________ ❑Gallbladder:__________ ❑Stent Placement:__________

❑Pacemaker:__________ ❑Fractures:__________ ❑Hernia Repair:__________

❑Arthroscopy:__________ ❑Hysterectomy:__________ ❑Tubal Ligation:__________

❑Cosmetic Surgery:__________ ❑Joint Replacement:__________

❑Other:__________

Any complications from a surgery? ❑No ❑Yes If **YES**, list problem(s):__________

Any complications from anesthesia? ❑No ❑Yes If **YES**, list problem(s):__________

SOCIAL HISTORY

Do you associate yourself with a specific Ethnicity? ❑Decline to specify ❑White ❑African American ❑Asian ❑American Indian ❑Hispanic or Latino ❑Middle Eastern ❑Pacific Islander ❑Other:__________

Language preference: ❑English ❑Spanish ❑Chinese ❑Korean ❑Japanese ❑Tagalog ❑Other:__________

Have you used tobacco before? ❑No ❑Yes If **YES**, do you currently use cigarettes? ❑No ❑Yes

❑Previous smoker If PREVIOUS how long has it been since you last smoked? ❑<1 mo ❑1-3 mo ❑3-6 mo ❑6-12 mo ❑1-5 yrs ❑5-10 yrs ❑>10 yrs

❑Current smoker If **CURRENT**, how many cigarettes per day?

❑5 or less ❑6-10 ❑11-20 ❑21-30 ❑31 or more

Do you drink alcohol? ❑No ❑Yes If **YES**, how often did you have a drink in the past year? ❑Monthly or less ❑2-4 times a month ❑2-3 times a week ❑4 or more times a week

Number of drinks per occasion? ❑1-2 drinks ❑3-4 drinks ❑5-6 drinks ❑7-9 drinks ❑10 or more drinks

Do you use Medicinal/Recreational drugs? ❑No ❑Yes If **YES**, please specify:__________

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Do you live alone? ❑Yes ❑No If **NO**, how many persons over 18 years old?__________

Do you have any Children? ❑No ❑Yes If **YES**, how many persons under 18 years old?__________

Are you currently employed? ❑No ❑Yes If **YES**, what is your Occupation?__________

If female, are you pregnant? ❑No ❑Yes

Sports:__________ Hobbies:__________

FAMILY HISTORY

Mother ❑Alive ❑Deceased Current Age/Age of Death____ ❑Healthy ❑Medical Problems:__________

Father ❑Alive ❑Deceased Current Age/Age of Death_____ ❑Healthy ❑Medical Problems:__________

Other family medical problems:__________

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TOTAL SPORTS MEDICINE & ORTHOPEDICS

PATIENT HISTORY Cont... (4 of 4 pages)

Patient Name: ______________________________ Date of Birth: ____________________

Do you have the following? Check all that apply.

CONSTITUTIONAL/GENERAL
- ❑ Weight Gain/Loss
- ❑ Fevers
- ❑ Chills
- ❑ Night sweats
- ❑ No fatigue
- ❑ Excessive sleep
- ❑ Lack of sleep

EYES
- ❑ Vision loss
- ❑ Blurred vision
- ❑ Double vision
- ❑ Rapid change in vision

CARDIAC
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Ankle or foot swelling
- ❑ Rapid or irregular heartbeat

RESPIRATORY
- ❑ Chronic cough
- ❑ Wheezing
- ❑ Cough up blood

ENDOCRINE
- ❑ Stomach pain
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Excessive thirst
- ❑ Excessive hunger
- ❑ Dry skin

URINARY
- ❑ Urinary incontinence
- ❑ Burning on urination
- ❑ Blood in urine
- ❑ Decrease of urine flow
- ❑ Frequent urination at night

EMOTIONAL/PSYCHIATRIC
- ❑ Depression
- ❑ Frequent or severe anxiety
- ❑ Hallucinations

HEMATOLOGIC
- ❑ Easy bruising
- ❑ Easy bleeding
- ❑ Frequent infections
- ❑ Low blood counts
- ❑ Prior transfusion

GASTROINTESTINAL
- ❑ Frequent Constipation
- ❑ Frequent diarrhea
- ❑ Blood in stool
- ❑ Vomiting
- ❑ Heartburn

NEUROLOGICAL
- ❑ Seizures
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Memory Loss
- ❑ Headache
- ❑ Weakness
- ❑ Loss of grip strength
- ❑ Numbness/tingling

MUSCULOSKELETAL
- ❑ Muscle pain
- ❑ Joint pain
- ❑ Muscle cramps
- ❑ Stiffness
- ❑ Rash
- ❑ Change in skin color
- ❑ Back pain
- ❑ Neck pain

TOTAL SPORTS MEDICINE & ORTHOPEDICS

FINANCIAL POLICY

Patient Name: ____ Date of Birth: __________________________

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Please initial below:

_______Our office does verify eligibility and benefits with your Health Insurance Company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status.

_______The patient's "responsible portion" is due at the time of service. This includes copayments. We will do all we can to assist you with your health insurance claims, however insurance is a contract between the insured and the insurance company.

_______Final responsibility for payment of your account rests with you. If you are scheduled for surgery, we may require a deposit, which must be paid prior to your date of surgery. Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

_______In the event that your account becomes delinquent, it will be forwarded to a collection agency. I agree to pay all incurred charges, collection agency fees, legal fees and court costs. If it is necessary to forward your account to a collection agency, a collection fee mark up of 35% - 50% will be added to the amount owed prior to have the account forwarded to the agency.

_______A returned check charge of $25 will be charged to my account for each returned check. If a returned check is not made whole (paying the original check amount plus the fees) the returned check will be sent to the Clark County District Attorney's office for additional processing.

_______Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medigap, Veterans' Administration or other designated payer of medical benefits to Dr. Joseph Yu, Dr. William R. McGee, and Van Nguyen PA-C for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of this assignment is considered as valid as the original.

_______There will be a $40 fee for any Family Medical Leave Act (FMLA) or Disability forms that must be filled out by Dr. Yu, Dr. McGee, or Van Nguyen, PA-C.

___________________________________ ___________________________________ ___________________________

Print Name (Parent/Guardian, if minor) Signature Date

____

SSN of Patient (Parent/Guardian, if minor)

TOTAL
SPORTS MEDICINE
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PRESCRIPTION DRUG POLICY

Patient Name: ____ Date of Birth: __________________________

New policies by the Drug Enforcement Agency (DEA) have forced us to create our own stricter rules regarding prescription drugs, beginning in our office **November 1, 2015**.

Narcotic pain pills can no longer be called into the pharmacy.

Narcotic pain pills are ONLY prescribed in our office for fractures (broken bones), after a surgery, or for other serious, acute injuries. We do not treat chronic pain.

If you have been given a narcotic pain prescription, this will **NOT** continue to be filled **after 8 weeks** after your injury or surgery. If you are still having pain issues that far out from injury or surgery, we will refer you to a pain management specialist, who can appropriately manage your pain and assist you in your transition away from these medications.

You cannot obtain prescriptions from more than one doctor. This information is tracked by the DEA and a second prescription will not be filled by the pharmacy.

ALL prescription drugs require documentation from an **office visit and examination** or the prescription is **ILLEGAL**. This means that if you feel you need a prescription of any kind, you will need an appointment to see the physician. This includes prescriptions that have been given to you in the past. If you are in need of a prescription and the physician is not in the office, you will need to see your primary care doctor, another doctor, or go to the Emergency Room or Urgent Care. **Plan ahead** if you recognize you may be running low on a prescription you are currently using.

By signing below, I acknowledge and agree to this policy.

____________________________________ ________________________________ ________________________
Print Name (Patient) Signature Date

____________________________________ ________________________________ ________________________
Print Name (Parent/Guardian) Signature Date

TOTAL
SPORTS MEDICINE
& ORTHOPEDICS

HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: ____ Date of Birth: __________________________

Acknowledgement and Receipt of Privacy Practices

Total Sports Medicine is required by US Federal Law to maintain our patients' privacy and provide them with access to the notice of our legal duties and privacy practices with respect to protected health information (PHI). Your signature below hereby acknowledges that you have reviewed our HIPAA Notice of Privacy Practices document and understand that you may obtain a copy for your records upon request.

____________________________________	_________________________________	________________________
Print Name (Parent, if minor)	Signature	Date

*If you would like a copy of our Privacy Practices, please ask.

TOTAL
SPORTS MEDICINE
& ORTHOPEDICS

HIPAA NOTICE OF PRIVACY PRACTICES

**Patient copy*

This is our privacy policy to protect your health information.
This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment to health care options, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "PHI" is information about you, including demographic information that may identify you and relates to your past, present or future physical or medical health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party, For example. we would disclose your PHI, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose
and treat you or to a home health agency that provides care to you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students who see patients at our office. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your next appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, Public Health issue; Communicable Disease; Health Oversight; Abuse or Neglect: FDA Requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensations; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and the Secretary of the Department of Health and Human Services, when required, to Investigate or determine our compliance with the requirements of section 164.500.Other permitted and required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law. You may revoke this authorization. at any time, in writing, except that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights

•Following is a statement of your rights with respect to your PHI.
•You have the right to inspect and copy your protected health information.
•You have the right to request a restriction of your protected health information.
•You have the right to have your physician amend your protected health information.

Complaint

You may complain to us or to the Secretary of Health of Human Services if you believe your privacy rights have been violated by us.
You may file a complaint with the Secretary of Health and Human Services by going through their website at www.hhs.gov.
For more information on HIPAA, please visit www.hipaa.org.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with any of our representatives in person or by phone.

TOTAL
SPORTS MEDICINE
& ORTHOPEDICS

Orthopaedic Solutions, LLC

10105 Banburry Cross Dr. Ste. 445
Las Vegas, NV 89144
Phone: (702) 475-4390 Fax: (702) 951-5456
www.totalsportsmedicine.com

Medical Records – Request / Release of Information

Date: ____________________

I (Please Print): ____ give permission to

Release/Obtain (Circle All Appropriate) ALL, SOAP NOTES, BILLING SURGICAL, DX, or
OTHER (Please Specify) ____ records to

Total Sports Medicine & Orthopedics

Office of Joseph Yu, MD, William R. McGee, DO, and Van Nguyen, PA-C

Please Choose Method of Transmittal

_____ Fax to (702) 951-5456 or other: ____________________

_____ Mail to 10105 Banburry Cross Dr. Ste. 445
Las Vegas, NV 89144

_____ Email to: _______________________________________

Requesting Medical Records FROM/TO:

Facility, Hospital or Doctor's Name: ____

Address: ____

Phone #: _________________________________ Fax #: ___________________________________

Patient Name (Last, First): __________________________________ Date of Birth: _____________

____
Name of Parent/Guardian,
IF Patient is under 18 years old

____
Signature of Patient (Parent/Guardian,
IF Patient under 18 years old)