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 (circle all that apply): Call / Email / Text
Ethnicity: ☐Decline to specify ☐Hispanic or Latino ☐Not Hispanic or Latino
Do you have an Advanced Directive/Living Will, Yes or No:_____

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 (circle 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)
Secondary Insurance:_____
Secondary Subscriber: _____ Subscriber Date of Birth:_____
Member ID:_____Group#_____ Relationship to patient:_____

WORKER COMPENSATION INFORMATION
Were you injured on the job? Yes or No:_____ If Yes, Date of Injury: _____

MOTOR VEHICLE ACCIDENT INFORMATION
Were you injured in a motor vehicle accident? Yes or No:_____ If Yes, Date of Injury: _____

I hereby sign to Dr. Joseph Yu and Dr. William R. McGee, 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

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PATIENT HISTORY

Patient Name:_____ Age:_____ Height:_____ Weight:_____
Primary Care Doctor: _____ Pharmacy:_____
Who referred you:_____
How did you find us? ☐Friend/Family ☐Yelp ☐Facebook ☐Google ☐Other:_____

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

ALLERGIES Medication(s):_____Reaction(s):_____
Non-Medication Allergies: ☐Metals ☐Iodine ☐Injections ☐Latex ☐IV Dye
☐Other:_____

MEDICATIONS- Please list medication, 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

Joint
☐Arthritis
☐Rheumatoid Arthritis
☐Reflex Sympathetic Dystrophy

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

Liver
☐Hepatitis
☐A B C
☐Kidney Problems
☐Cancer _____
☐HIV

Other: _____
_____

Psychiatric Problems
☐Anxiety
☐Depression

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PATIENT HISTORY Cont...

Patient Name:_____ Date of Birth:_____

Which body part is involved? _____ ☐Right ☐Left ☐Both
What is the problem? ☐Pain ☐Instability ☐Stiffness ☐Swelling
☐Other _____
What date did the problem begin? _____ How did it start?_____
Where do you feel the pain? _____
What is the nature of the pain ☐Dull ☐Sharp ☐Burn ☐Other _____
Radiation of the pain: ☐No radiation ☐Back ☐Hip ☐Thigh ☐Knee ☐Foot ☐Arm ☐Neck ☐Hand
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 that wakes you up at night
What are some things that you can't do anymore (because of the pain)? _____
_____
Are you currently working? ☐Yes ☐No
Do you use assistive devices: ☐No ☐Brace ☐Cane ☐Crutches ☐Walker ☐Wheelchair
☐Other _____
Is your walking distance limited by the pain? ☐Yes ☐No Walking distance: ☐Less than a block ☐1-2 ☐3-6 ☐>6
Have you seen any other doctor for this problem? ☐No ☐Yes (please list)_____
Have you had surgery in the area you are having pain? ☐No ☐Yes (name, specialty)
_____
Had steroid (ie: cortisone) injections? ☐No ☐Yes Did it help? ☐No ☐Yes
For how long? _____ ☐Weeks ☐Months
Had viscosupplementation (lubricant) injections? ☐No ☐Yes Did it help? ☐No ☐Yes
For how long? _____ ☐Weeks ☐Months
Had physical therapy? ☐No ☐Yes How many weeks? _____ Did it help? ☐No ☐Yes
Did you take medications to relieve the pain? ☐No ☐Yes
Name: _____ Pills per day: _____
Name: _____ Pills per day: _____
Name: _____ Pills per day: _____

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PATIENT HISTORY Cont...

Patient Name:_____ Date of Birth:_____

SURGICAL HISTORY- Please list surgeries and include dates.

☐Tonsillectomy:_____ ☐Coronary Artery Bypass:_____
☐Breast Cancer:_____ ☐Appendectomy:_____
☐Gallbladder:_____ ☐Stent Placement:_____
☐Pacemaker:_____ ☐Fractures:_____
☐Hernia Repair:_____ ☐Arthroscopy:_____
☐Hysterectomy:_____ ☐Joint Replacement:_____
☐Tubal Ligation:_____ ☐Cosmetic Surgery:_____
Other:_____
Any complications from a surgery?_____
Any complications from anesthesia?_____

SOCIAL HISTORY

Do you smoke? ☐No ☐Yes How many packs per day?_____ For how many years?_____
☐Married ☐Single ☐Widowed ☐Children? _____
Occupation: _____
Do you live alone? ☐No ☐Yes Who lives with you? _____
Do you drink alcohol? ☐No ☐Yes How Much? ☐Daily____ drinks ☐Occasional____ drinks ☐Weekend____ drinks
Recreational drug use? ☐No ☐Yes _____
If female, are you pregnant? ☐No ☐Yes Sports:_____
Hobbies:_____

FAMILY HISTORY

Mother ☐Alive/Age_____ ☐Healthy ☐Medical Problems:_____
☐Deceased/age & cause_____
Father ☐Alive/Age_____ ☐Healthy ☐Medical Problems:_____
☐Deceased/age & cause_____
Other family medical problems:_____
_____

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PATIENT HISTORY Cont...

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 and Dr. William R. McGee 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 or Dr. McGee.

_____ _____ _____

Print Name (Parent, if minor) Signature Date

TOTAL SPORTS MEDICINE & ORTHOPEDICS

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.