TOTAL
SPORTS MEDICINE
& ORTHOPEDICS

PATIENT INFORMATION

Patient Name: _____ ☐ Dr ☐ Mr ☐ Mrs ☐ Ms

Date of Birth: _____ SSN: _____ (required for billing)

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Preferred contact: ☐ Call ☐ Email ☐ Text

Do you have an Advanced Directive/Living Will? ☐ No ☐ Yes: _____

Who referred you? ☐ Yelp ☐ Google ☐ Friend/Family/other: _____

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: _____

Preferred contact: ☐ 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: _____

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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.

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. By signing below, I agree to pay all incurred charges, legal fees and court costs.

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 Orthopedic Solutions LLC for services furnished to me. The 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 $75 fee for all Family Medical Leave Act (FMLA) or Disability forms that must be filled out by Joseph Yu MD, William R. McGee DO, Van Nguyen PA-C and Samantha Laub PA-C. Fee covers 6 months of revision to paperwork.

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

_____
Social Security # (Patient/Guardian, if minor)
Required for Insurance and Billing purposes.

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Time In:
DOB:
Chart #:
Room#:

Patient Name: _____

Age: _____ Height: _____ Weight: _____

Have you had any of these: ☐ x-ray ☐ MRI ☐ CT where: _____

Sport history (if applicable): ☐ HS ☐ College Sport: _____

What body part bothers you? _____

What side? ☐ right ☐ left When did it start? _____

Describe the problem: ☐ constant ☐ intermittent ☐ dull ☐ sharp ☐ burn

_____

_____

Check all that apply: ☐ pain radiates where: _____

☐ instability ☐ stiffness ☐ weakness ☐ numbness

Worse with: ☐ sitting ☐ standing ☐ walking ☐ bending ☐ stairs

☐ lifting ☐ overhead activities ☐ reaching back

☐ pain wakes you up at night

☐ use crutches/walker/wheelchair

Were you injured in a motor vehicle accident? ☐ No ☐ Yes _____

Was there an injury? ☐ No ☐ Yes _____

Was it on the job? ☐ No ☐ Yes _____

Have you had any of the following treatments for this issue:

☐ injection ☐ surgery ☐ physical therapy

☐ evaluation by Orthopedic Surgeon _____

☐ medications for pain: _____

For Office Use:

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Patient Name: _____

Primary Care Doctor Name: _____

Primary Care Phone: _____

Pharmacy Name: _____

Pharmacy Address: _____

Phone: _____

ALLERGIES

Medication: _____ Reactions: _____

Medication: _____ Reactions: _____

Non-Medication Allergies: ☐ Metals ☐ Iodine ☐ Injections ☐ Latex ☐ IV Dye ☐ Other: _____

MEDICATIONS Please list all medications you are taking

Medication: _____ Reason: _____ Medication: _____ Reason: _____

Medication: _____ Reason: _____ Medication: _____ Reason: _____

Medication: _____ Reason: _____ Medication: _____ Reason: _____

Medication: _____ Reason: _____ Medication: _____ Reason: _____

MEDICAL HISTORY Please check all that apply.

☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Type I ☐ Type II

Heart ☐ Coronary Artery Disease ☐ Heart Attack ☐ Congestive Heart Failure ☐ Arrhythmias

Lung ☐ Asthma ☐ COPD ☐ Sleep Apnea ☐ Kidney Failure

Gastrointestinal ☐ GERD ☐ Peptic Ulcer

Hematology ☐ Blood Clots ☐ Bleeding Disorder ☐ Cancer _____

Infectious ☐ Hepatitis ☐ A ☐ B ☐ C ☐ D

Endocrine ☐ Osteoarthritis ☐ Rheumatoid Arthritis

Psychiatric Problems ☐ Anxiety ☐ Depression

Other: _____

_____

_____

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SURGICAL HISTORY Please list surgery and date of surgery.

Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____

Any complications from a surgery? ☐ No ☐ Yes: _____
Any complications from anesthesia? ☐ No ☐ Yes _____

SOCIAL HISTORY

☐ Ethnicity _____
☐ Languages _____
☐ Non-smoker
☐ Current smoker. How much do you smoke? _____
☐ Former smoker. When did you quit? _____
Do you drink alcohol? ☐ No ☐ Yes How often did you have a drink in the past year? _____
Do you use recreational drugs? ☐ No ☐ Yes, Please specify: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Do you have any children? ☐ No ☐ Yes, how many? _____
Are you currently employed? ☐ No ☐ Yes, what is your occupation? _____
If female, are you currently pregnant? ☐ No ☐ Yes _____
Do you exercise? ☐ No ☐ Yes, how often: _____
Hobbies: _____

FAMILY HISTORY

Mother: ☐ Alive ☐ Deceased Medical Problems: _____
Father: ☐ Alive ☐ Deceased Medical Problems: _____
Other: _____

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Do you have the following? Check all that apply.

CONSTITUTIONAL

☐ Fever/Chills ☐ Weight gain/loss ☐ Fatigue ☐ Excessive/Lack of sleep

EYES

☐ Vision changes ☐ Blurred vision ☐ Double vision

ENNT

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

CARDIOVASCULAR

☐ Chest pain ☐ Irregular heart beat ☐ Leg swelling

RESPIRATORY

☐ Shortness of breath ☐ Wheezing

GASTROINTESTINAL

☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

GENITOURINARY

☐ Urinary incontinence ☐ Urinary retention ☐ Urinary frequency ☐ Burning

INTEGUMENTARY

☐ Rash ☐ Hair loss ☐ Skin lesion

NEUROLOGICAL

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

PSYCHIATRY

☐ Anxiety ☐ Depression ☐ Hallucination

ENDOCRINE

☐ Heat/col ☐ ntolerance ☐ Excessive thirst/hunger ☐ Dry skin

HEMOTOLOGY

☐ Easy bruising/bleeding ☐ Anemia ☐ Prior transfusion:

IMMUNOLOGIC

☐ Seasonal allergies ☐ Hay fever symptoms ☐ HIV

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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, if minor)	Signature	Date

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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.

I hereby sign to Orthopaedic Solutions LLC 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 (Patient)	Signature	Date
_____	_____	_____
Print Name (Parent/Guardian, if minor)	Signature	Date

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