Tahoe Orthopedics & Sports Medicine

Patient Information

Legal Name: _____ Nickname/Alias: _____

Social Security # _____-_____-_____ □ Male □ Female Date of Birth: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Temporary Address: _____ From: _____ To: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other (**Please Explain**): _____

Email Address: _____

Primary Spoken Language: _____ Do you need an interpreter? Yes _____ No _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Religion: _____ Veteran Status: □ Yes □ No

Ethnicity: Non-Hispanic _____ Hispanic _____ Race: _____

Primary Care Physician: _____

Referring Physician: _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone #'s: (Home) _____ (Cell) _____

Patient's Occupation: _____ □ Self-Employed □ Student □ Retired □ Disabled

Patient's Employer: _____ **Employment Status:** □ Full-Time □ Part-Time □ Other

Responsible Billing Party/Subscriber **if Other Than Patient**: _____

Employer: _____ **Employment Status:** □ Full-Time □ Part-Time □ Other

SSN# _____ DOB: _____ **Relationship to Guarantor/Insured:** _____

Insurance: Primary _____ Secondary _____

Tahoe Orthopedics & Sports Medicine

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION:

I GIVE MY CONSENT FOR TREATMENT:

I hereby authorize the release of any appropriate medical information to my insurance company. I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans. This assignment will remain in effect until revoked by me in writing.

We make every reasonable effort to obtain pre-approval, prior authorization and referral information. Your co-payment, coinsurance and/or deductible are due in full at the time of service. We will bill your insurance as a courtesy to you. On denied worker compensation claims, the patient's private/group health insurance may be billed. Ultimate financial responsibility remains with the patient and if the insurance company or worker compensation carrier denies payment, the bill is your responsibility. If you are unsure of any of these issues, please ask the staff before you see the physician.

Print Name: _____

Signature: _____ Date: _____

Tahoe Orthopedics & Sports Medicine

Patient Record of Disclosures

Please Fill Out Completely

Who may we release medical information to?

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

I wish to be contacted in the following manner (check all that apply), and

indicate your <u>primary</u> method of contact by <u>underlining</u> one of the following:

Home Phone □ Okay to leave message with detailed information

□ Leave message with call back number and name of Tahoe Orthopedics & Sports Medicine only

Work Phone □ Okay to leave message with detailed information

□ Leave message with call back number and name of Tahoe Orthopedics & Sports Medicine only

Cell Phone □ Okay to leave message with detailed information

□ Leave message with call back number and name of Tahoe Orthopedics & Sports Medicine only

Email/Other _____

Print Name: _____

Signature: _____ Date: _____

Tahoe Orthopedics & Sports Medicine

Name: _____ **Date:** _____

Height: _____ **Weight:** _____ **Age:** _____ **Pain Rating:** _____

Referring Physician: _____ **VITAL SIGNS: TEMP** _____ **PULSE** _____ **RESP** _____ **BP** _____

Chief Complaint:

What is the main problem that brings you in today? _____

_____

Pain Assessment

Location of Pain: (body part) _____ **Please circle:** LEFT RIGHT BOTH

Severity of Pain: 0 1 2 3 4 5 6 7 8 9 10

Quality of Pain: (Circle all that apply)

Throbbing Sharp Dull Aching Locking Grinding Popping Cracking Buckling

Symptoms: (Circle all that apply)

Buckling Catching Cracking Crepitus Giving-Way Grinding Locking Popping

Duration of Pain: (Circle all that apply)

A few minutes A few hours A few days Persistent

Frequency of pain: (Circle all that apply)

Rarely Once a week Several days a week Several times a day Intermittent Occassional Constant Frequent

Date pain started: _____

Aggravating Factors: (Circle all that apply)

Activity Bending Exercise Grasping Gripping Kneeling Pivoting Reaching Running Sports Squatting Stairs Straightening Streching Standing Walking

Limiting Behavior: YES NO

Relieving Factor: (Circle all that apply)

Rest Ice Heat Exercise NSAIDS

Result of Injury: YES NO

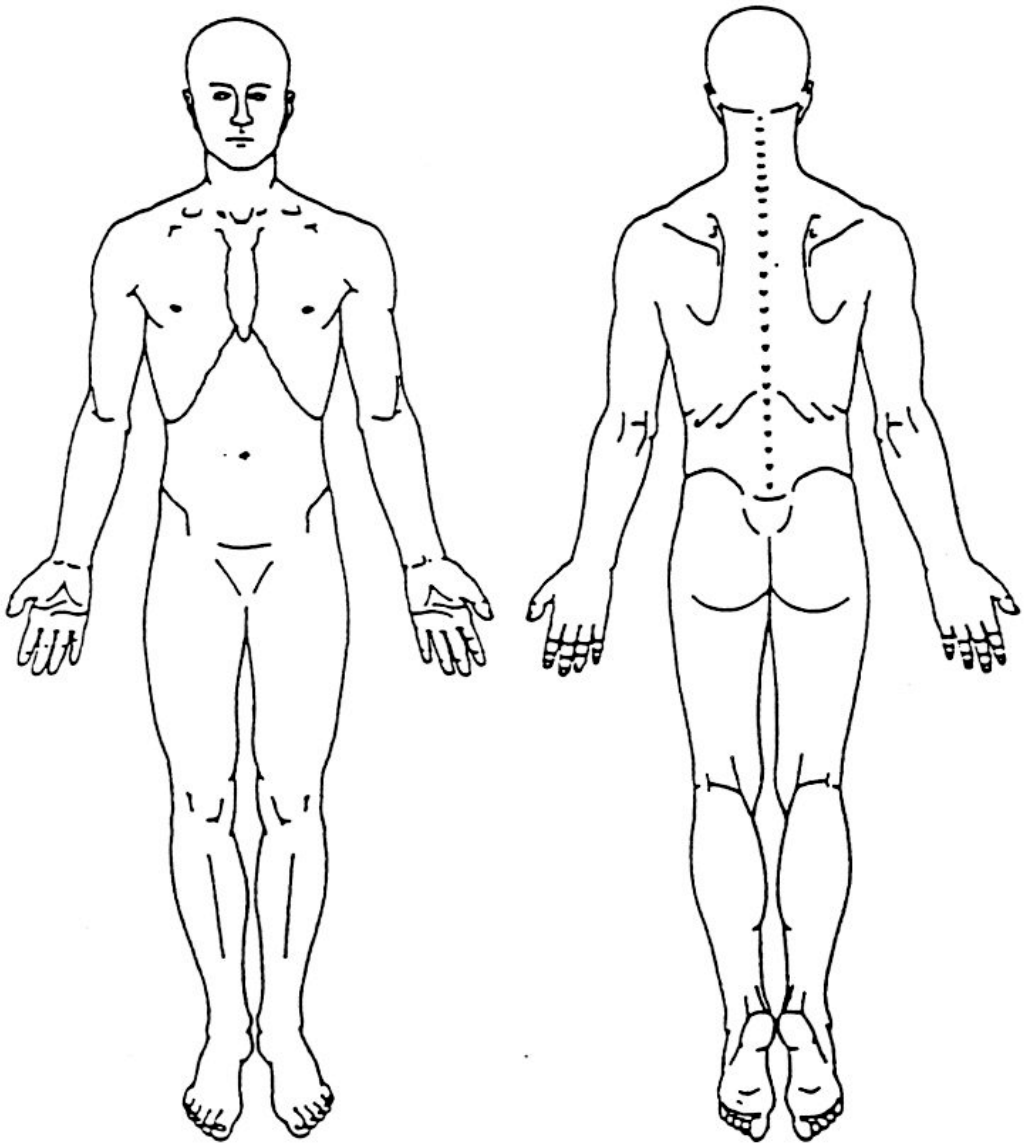
Work-Related Injury: YES NO

Tahoe Orthopedics & Sports Medicine

Note the location of your pain on these drawings. (If the back of your neck is painful, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the symbols on the diagrams.

Numbness ======== Pins and needles oooooooooo Ache ^^^^^^^^^^

Burning XXXXXXXX Stabbing //////////////



_____ _____ _____ _____

Patient's Signature Date Physician's Signature Date

Which of the following have you had?					Did the treatment make you:		
	Other	Low Back	Mid Back	Neck	Better	No Change	Worse
Physical Therapy							
Occupational Therapy							
Chiropractic / Osteopathic							
Acupuncture							
Regular X-rays							
MRI Scan							
CT Scan							
EMG / NCV							

Have you had any surgeries or fractures? Please List the dates.

	Dates

Please list all food and drug allergies:

	Reactions

Medications (you may attach separate list):

Patient Medical History

Patient Name: _____ **Date of Birth:** _____

Medical History (PLEASE INDICATE YES OR NO BY CIRCLING THE APPROPROATE ANSWER)

Addison's Disease	YES	NO	Congestive Heart Failure	YES	NO
Adrenal Disorder	YES	NO	Clotting Disorder	YES	NO
Allergies	YES	NO	Chronic Obstructive Pµlmonary Disease	YES	NO
Anemia	YES	NO	Cushing's Syndrome	YES	NO
Anxiety	YES	NO	Depression	YES	NO
Arrhythmia	YES	NO	Diabetes Mellitus	YES	NO
Arthritis	YES	NO	Diabetic Neuropathy	YES	NO
Asthma	YES	NO	Emphysema	YES	NO
Blood Transfusion	YES	NO	GERD	YES	NO
Cancer	YES	NO	Glaucoma	YES	NO
Cataracts	YES	NO	Goiter	YES	NO
Headache	YES	NO	Nerve/Muscle Disorder	YES	NO
Heart Attack	YES	NO	Osteoporosis	YES	NO
Heart Murmur	YES	NO	Pituitary Disease	YES	NO
HIV/AIDS	YES	NO	Seizures	YES	NO
High Cholesterol	YES	NO	Sickle Cell	YES	NO
Parathyroid Disorder	YES	NO	Stroke	YES	NO
High Blood Pressure	YES	NO	Substance Abuse	YES	NO
Inflammatory Bowel	YES	NO	Thyroid Disease	YES	NO
Kidney Disease	YES	NO	Tuberculosis	YES	NO
Meningitis	YES	NO	Ulcer	YES	NO
Migraine	YES	NO	Urinary Tract Infection	YES	NO

Other/Not Listed:_____

_____

_____

Review of Systems

Patient Name: _____ **Date of Birth:** _____

General (Circle all that apply. If none apply, circle "none"):
Fever Chills Diaphoresis/Sweats Weight Loss Malaise/Fatigue Weakness
None Other:_____

Skin (Circle all that apply. If none apply, circle "none"):
Rash Itching None Other: _____

Head, Ears Nose, Throat (Circle all that apply. If none apply, circle "none"):
Headaches Hearing Loss Tinnitus/Ringing in Ears Ear Pain Ear Discharge Nosebleeds Congestion Stridor Sore Throat
None Other: _____

Eyes (Circle all that apply. If none apply, circle "none"):
Blurred Vision Double Vision Photo phobia/Light Sensitivity Eye Pain Eye Discharge Eye Redness
None Other: _____

Cardiovascular (Circle all that apply. If none apply, circle "none"):
Chest Pain Palpitations Orthopnea/Shortness of Breath Claudication/Leg Weakness/Limp Leg Swelling
PND(Paroxysmal Nocturnal Dyspnea) None Other: _____

Respiratory (Circle all that apply. If none apply, circle "none"):
Cough Hemoptysis/Coughing Blood Sputum Production Shortness of Breath Wheezing
None Other: _____

Gastrointestinal (Circle all that apply. If none apply, circle "none"):
Heartburn Nausea Vomiting Abdominal Pain Diarrhea Constipation Blood in Stools Melena/Black stools
None Other: _____

Genitourinary (Circle all that apply. If none apply, circle "none"):
Dysuria/Painful Urination Urgency Increase Frequency Hematuria/Blood in Urine Flank pain
None Other: _____

Musculoskeletal (Circle all that apply. If none apply, circle "none"):
Myalgia/Muscle pain Neck Pain Back Pain Joint Pain Falls
None Other: _____

Endocrine/Hematologic/Lymphatic (Circle all that apply. If none apply, circle "none"):
Easy to Bruise/Bleed(Anemia) Environmental Allergies Polydipsia/Excessive Thirst
None Other: _____

Neurological (Circle all that apply. If none apply, circle "none"):
Dizziness Tingling Tremor Sensory ChangeSpeech Change Focal Weakness Seizures Loss of Consciousness
None Other: _____

Psychiatric (Circle all that apply. If none apply, circle "none"):
Depression Suicidal Ideas Substance Abuse Hallucinations Nervousness/Anxious Insomnia Memory Loss
None Other: _____

Family Health History Questionaire

Please Check Only Positives

	Mother	Father	Sister 1	2	3	Brother 1	2	3	Other
Deceased Y/N									
ADHD									
Alcohol/Drug									
Allergies									
Anemia									
Anesthesia									
Anxiety									
Arrhythmia									
Arthritis									
Asthma									
Bipolar Disorder									
Bladder Cancer									
Blood Disease									
Cancer									
Clotting Disorder									
Dementia									
Depression									
Diabetes									
DVT-Blood Clots									
Fainting									
Genetic Disorder									
Genitourinary									
Gastrointestinal									
Heart Attack									
Heart Disease									
Heart Failure									
High Cholesterol									
Hypertension									
High BP									
Kidney Cancer									
Kidney Stones									
Lung Disease									
OCD									
Osteoporosis									
Other									
Paranoid Behave									
Physical Abuse									
Prostate Cancer									
Prostate Enlarge									
Prostatitis									
Psychiatry									
Recurrent UTI									
Rheumatologic									
Schizophrenia									
Scoliosis									
Seizures									
Sexual Abuse									
Stroke									
Testitis Cancer									
Thyroid									

Tahoe Orthopedics & Sports Medicine

Social and Family History:

Are you married, single, widowed or divorced? **Are you right or left handed?**

How many children do you have?

What is your occupation? **Are you currently working?**

Are you on Workmen's Compensation?

Alcohol/Drugs: **What is your approximate weekly use of alcoholic beverages?**

____ I don't drink alcohol.
____ Less than 1-2 drinks a week.
____ 3-6 drinks a week.
____ Drink some alcohol on a daily basis.

Have you or a parent ever had a problem with:

Alcoholism: ____You ____ Parent ____ No Drug Abuse: ___ You ___ Parent ___ No

Tobacco: What is your approximate daily use of tobacco?

___ I don't smoke **___ 1 pack per day** **___ More than 2 packs per day**
___ ½ pack per day **___1-2 packs per day**

Opioid Risk Tool		
Family History of Substance Abuse		
Alcohol:	YES	NO
Illegal Drugs:	YES	NO
Prescription Drugs:	YES	NO
Personal History of Substance Abuse		
Alcohol:	YES	NO
Illegal Drugs:	YES	NO
Prescription Drugs:	YES	NO
Psycholgical / Social History		
Preadolescent Sexual Abuse:	YES	NO
ADD, ADHS, OCD, Bipolar, Schizophrenia:	YES	NO
Depression:	YES	NO