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 ____

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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: ________________________

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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 primary method of contact by underlining 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: ____

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Name: ____ Date: ____________________

Height: ______________ Weight: ___________ Age: _________ Pain Rating: _____________
(Pain Scale of 1 to 10, with 10 being extreme pain)

Referring Physician: _______________________ VITAL SIGNS : TEMP ______ PULSE _____ RESP _______ BP _______

<u>Chief Complaint:</u>

What is the main problem that brings you in today?

<u>History of Present Illness:</u>

Please describe your symptoms, including any numbness, pain or weakness.

When did your symptoms begin and how have they progressed?

How did the injury or symptoms begin? Are they the result of an acute injury or accident?

Which diagnostic studies have you had? What has been your diagnosis?

Which doctors have you seen for this problem? What treatments have you had?

What activities, positions or treatments make your symptoms better?

What activities, positions or treatments make your symptoms worse?

What activities would you like to be able to do?

Has surgery been mentioned for this problem?

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							

<u>Past Medical History:</u>

Please list any current and past medical conditions or problems.

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):

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Social and Family History:

Are you married, single, widowed or divorced?

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

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Please circle YES or NO next to each of the following conditions you might have now or before.

Condition		Condition	
Addison's Disease	**Yes No**	**Decreased concentration**	**Yes No**
Adrenal Disorder	**Yes No**	**Depression**	**Yes No**
Allergies	**Yes No**	**Diabetes**	**Yes No**
Anemia	**Yes No**	**Dry Eyes or mouth**	**Yes No**
Anger	**Yes No**	**Emphysema**	**Yes No**
Anxiety	**Yes No**	**Excessive fatigue**	**Yes No**
Eye, Ear, Nose, Throat, Lung, Heart, Stomach, Kidney or Skin disorders			**Yes No**
Arrhythmia	**Yes No**	**Family dysfunction**	**Yes No**
Arthritis	**Yes No**	**Fibromyalgia**	**Yes No**
Asthma	**Yes No**	**Generalized morning stiffness**	**Yes No**
Blood in stool	**Yes No**	**GERD**	**Yes No**
Blood in urine	**Yes No**	**Glaucoma**	**Yes No**
Blood Transfusion	**Yes No**	**Goiter**	**Yes No**
Cancer	**Yes No**	**Heart burn or reflux**	**Yes No**
Cataracts	**Yes No**	**Headache**	**Yes No**
Chemical Exposures	**Yes No**	**Heart attack**	**Yes No**
CHF	**Yes No**	**Heart murmur**	**Yes No**
Chills	**Yes No**	**HIV/AIDS**	**Yes No**
Clotting Disorder	**Yes No**	**Hyperlipidemia**	**Yes No**
COPD	**Yes No**	**Hypertension**	**Yes No**
Cushings Syndrome	**Yes No**	**Inability/difficulty w/urination**	**Yes No**
Infections (circle): MRSA / HIV / HEP A B C / OTHER_________________________________			
Inflammatory bowel	**Yes No**	**Persistent eye redness**	**Yes No**
Insomnia	**Yes No**	**Pituitary disease**	**Yes No**
Joint pain or swelling	**Yes No**	**Problems w/sexual function**	**Yes No**
Kidney disease	**Yes No**	**Seizures**	**Yes No**
Loss of appetite	**Yes No**	**Sickle Cell**	**Yes No**
Loss of bladder control	**Yes No**	**Skin rashes**	**Yes No**
Loss of bowel control	**Yes No**	**Stomach pain**	**Yes No**
Loss of sensation around		**Stomach or Intestinal ulcers**	**Yes No**
groin or buttocks	**Yes No**	**Stroke**	**Yes No**
Lupus	**Yes No**	**Swollen ankles**	**Yes No**
Migraine	**Yes No**	**Substance abuse**	**Yes No**
Memory difficulties	**Yes No**	**Taking blood thinners**	**Yes No**
Meningitis	**Yes No**	**Thyroid disease**	**Yes No**
Muscle tenderness	**Yes No**	**Trouble breathing w/exercise**	**Yes No**
Nausea	**Yes No**	**Trouble breathing lying flat**	**Yes No**
Need to urinate more		**Tuberculosis**	**Yes No**
at night	**Yes No**	**Ulcer**	**Yes No**
Night sweats	**Yes No**	**Unexplainable fevers**	**Yes No**
Neuropathy	**Yes No**	**Unusual stress in home life**	**Yes No**
Nerve/Muscle disorder	**Yes No**	**Unusual stress in work life**	**Yes No**
Osteoporosis	**Yes No**	**UTI**	**Yes No**
Pain or burning when		**Weight loss or gain_____lbs**	**Yes No**
urinating	**Yes No**		

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 Occasional Constant Frequent

Date pain started: ______________________

Aggravating Factors: (circle all that apply)

Activity Bending Exercise Grasping Gripping Kneeling

Pivoting Reaching Running Sports Squatting Stairs

Straightening Stretching Standing Walking

Limiting Behavior: YES NO

Relieving Factors: (circle all that apply)

Rest Ice Heat Exercise NSAIDS

Result of Injury: YES NO

Work-Related Injury: YES NO

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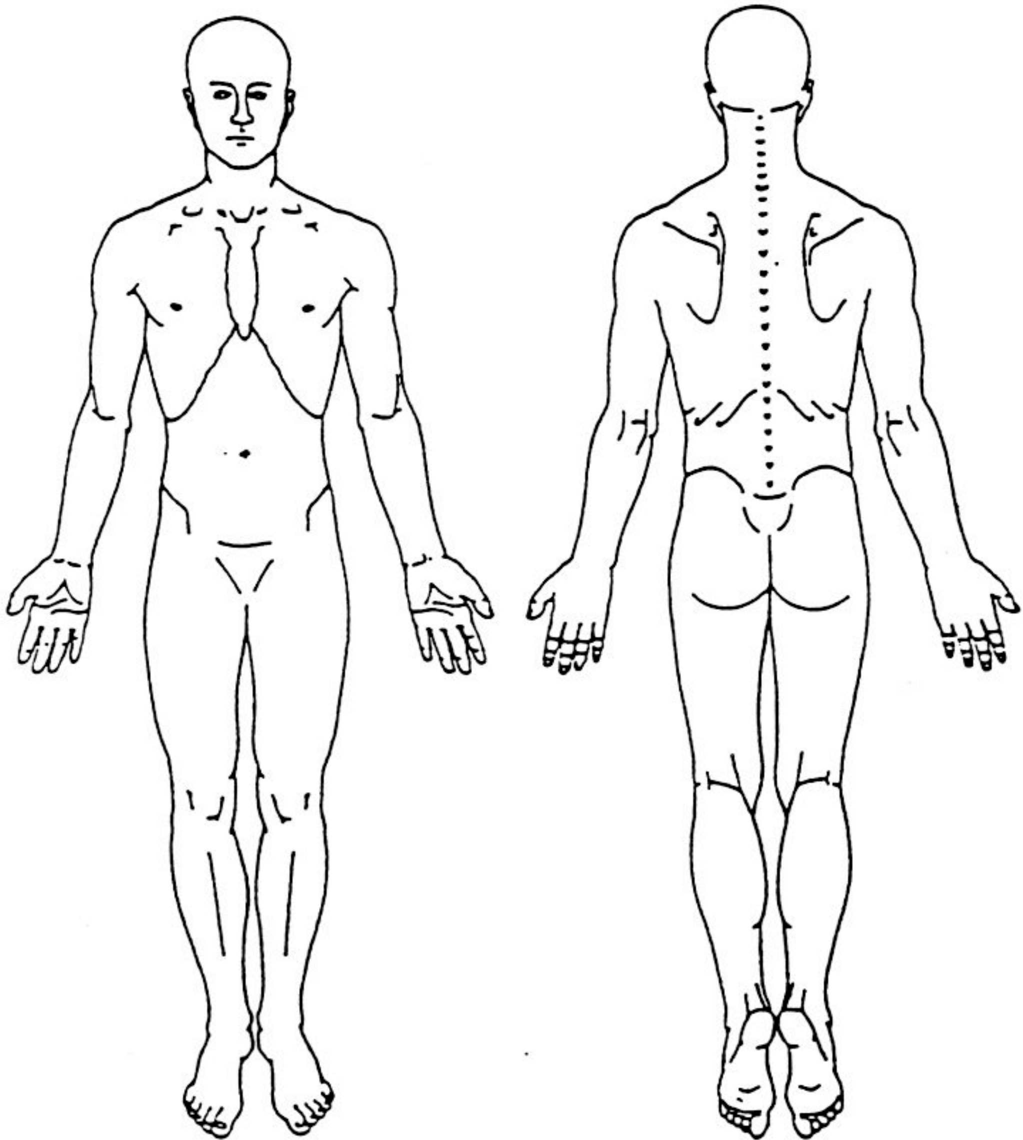
Note the location of your pain on these drawings. (If the back of your neck is painful, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the symbols on the diagrams.

Numbness	========	Pins and needles	oooooooooo Ache ^^^^^^^^^^^^^^
Burning	XXXXXXXX	Stabbing	/////////////



Patient's Signature ______________________ Date ____________ Physician's Signature ______________________ Date ____________

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									