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

Patient Medical Information

Patient Name: ____ Date: ____________________________

Chief Complaint/ Body Part:

____

Date of Injury: ______________________________________

Where /how did the injury occur?

____

____

Medical Conditions (Mark and/or list):

Claustrophobic		Metal in the body	
Diabetic		Multiple Myeloma	
Stents, Shunts, Pacemaker		Renal Dysfunction (Kidney)	
MRSA Exposure		New Injury or Trauma	

Other:

____

Height: __________ Weight: ___________

Do you use or have a history of using:

Alcohol? Never ______ Rarely ______ Moderate ______ Daily ______

Tobacco? Never _____ Yes _____ How many? _____ packs per day, for ______ years.

Quit _____ years ago.

Recreational Drugs? Never _____ Quit _____ years ago.

Type/Frequency: ____

Tahoe Orthopedics & Sports Medicine

Patient Medical Information / Med List

Patient Name: ____ Date: ______________________

Preferred Pharmacy: _____________________________________ Location: ______________________

Current Medications: □ Do not take any medications.

Name of Drug:	Strength:	Dose:	Last Took Medication:
__________________________	__________	_______________	_____________________________
__________________________	__________	_______________	_____________________________
__________________________	__________	_______________	_____________________________
__________________________	__________	_______________	_____________________________
__________________________	__________	_______________	_____________________________
__________________________	__________	_______________	_____________________________
__________________________	__________	_______________	_____________________________

Allergies: □ No known allergies.

Do you have any drug/food/metal/latex allergies? □ Yes □ No

If yes, please list the allergy and the reaction:

Allergic to:	Reaction:
____	____
____	____
____	____
____	____
____	____

Tahoe Orthopedics & Sports Medicine
Barton Health

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 Pulmonary 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: ____

____

Orthopedic History (Include fractures and/or orthopedic surgeries):

____

____

____

____

____

____

Other Surgeries (Tonsils, Appendix, etc.):

____

____

____

____

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

Review of Systems

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 Photophobia/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 Change Speech 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									