ADVANCED ORTHOPEDICS & SPORTS MEDICINE

SEP BADY, MD
THOMMAN KURUVILLA, DPM
EUGENE LIBBY, DO., F.A.C.O.S
X. NICK LIU, DO
MATTHEW HC OTTEN, DO
TIMOTHY J. TRAINOR, MD
MICHAEL A. TRAINOR, DO
RANDALL E. YEE, DO

Today's Date:_____

Last Name:_____ First Name:_____ DOB:_____

Address:_____Zip:_____

SSN:_____ Home Phone#:_____ Cell Phone#_____

Language:_____ Race:_____ Ethnicity: Hispanic / Not Hispanic

Height:_____ Weight:_____ Gender: Male ☐ Female ☐

Employer_____ Occupation_____ Work#_____

Email:_____

Pharmacy Name_____ Pharmacy #_____

Pharmacy Address_____ PCP_____

Who can we thank for referring you to our office? _____

FOR XRAY PURPOSES:

ARE YOU PREGNANT OR IS THERE A POSSIBILITY YOU MAY BE PREGNANT? ☐ YES ☐ NO

WHAT ARE WE SEEING YOU FOR TODAY?

PLEASE CIRCLE RIGHT OR LEFT FOR EACH BOTH PART INVOLVED

1.) _____ RIGHT LEFT

2.) _____ RIGHT LEFT

WHAT DO YOU THINK CAUSED WHAT WE ARE SEEING YOU FOR TODAY? _____

WHAT DATE DID THE PROBLEM START? _____

IF THIS IS AN INJURY, WHERE DID IT OCCUR? _____

DO YOU HAVE AN ATTORNEY FOR THIS INJURY? ☐ YES ☐ NO

ATTORNEY NAME: _____ PHONE #: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Address: _____

Phone: _____

Policy/ID #: _____

Group #: _____

Policy Holder Information

Last Name: _____ M.I. _____

First Name: _____

DOB: _____ SSN: _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

Address:_____

Phone: _____

Policy/ID #: _____

Group #: _____

Policy Holder Information

Last Name: _____ M.I. _____

First Name: _____

DOB: _____ SSN: _____

Relationship to Patient: _____

IF PATIENT IS A MINOR PERSON RESPONSIBLE FOR BILL'S

LAST NAME: _____FIRST:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

HOME PH: (_____) _____ WORK PH: (_____)_____CELL PH: (____)_____

SSN:_____ GENDER: ☐ M ☐ F DATE OF BIRTH: _____/_____/_____ AGE: _____

EMERGENCY CONTACT

NAME OF LOCAL FRIEND OR RELATIVE:

LAST NAME: _____ FIRST NAME: _____ RELATIONSHIP: _____

HOME PH: (____) _____ WORK PH: (____)_____CELL PH: (____)_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I hereby assign my healthcare benefit payments, to which I am entitled through my insurance company to Advanced Orthopedics and Sports Medicine. This assignment is pursuant to the Employee Retirement Income Security Act (ERSA) as defined in 29 CFR 2560-503-1, and applicable State law, and it will remain in the effect until revoked by me in writing.

I understand that I am that I am financially responsible for all the charges not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Advanced Orthopedics and Sports Medicine is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefit payments or adverse benefit determinations as defined in 29 CFR 2560-503-1, with the State Insurance Commissioner for a possible violation of State Insurance Laws or the Employee Benefits Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 18§§1003(a) and 1144(a).

Advanced Orthopedics and Sports Medicine is allowed full discovery of any and all information, documentation, policies, procedure and resources used by my insurance company, to perform an adverse benefit determination, as defined in 29 CFR 2560-503-1 of my covered health benefits.

Advanced Orthopedics and Sports Medicine is authorized to represent me in any and all Federal Lawsuits against my insurance company pursuant to the ERISA> A copy of this document is as valid as the original.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

HIPPA

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THE FOLLOWING:
PHYSICIANS, FAMILY, INSURANCE, SHORT TERM DISABILITY PROVIDERS, ETC.

PATIENT NAME (LAST, FIRST): _____ DATE OF BIRTH: _____/_____/_____

NAME OF PARENT OR GUARDIAN IF PATIENT IS A MINOR: _____

IN THE EVENT THAT AOSM MAY NEED TO GIVE YOUR TEST RESULTS OR MEDICAL INFORMATION, MAY *WE:*

_____ LEAVE DETAILED MESSAGE ON AN ANSWERING MACHINE

_____ LEAVE A MESSAGE WITH MY SPOUSE OR FAMILY MEMBER

_____ CALL YOU ON YOUR CELLULAR PHONE; THE PHONE NUMBER IS: (_____)_____

_____ CALL YOU AT WORK; THE PHONE NUMBER IS: (_____)_____

I GIVE ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, DR. BADY, DR. KURUVILLA, DR. LIU, DR. OTTEN, DR. T. TRAINOR, DR. M. TRAINOR AND/OR DR. YEE AND STAFF THE AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY, FRIENDS, CAREGIVER, PHYSICAN, INSURANCE AND/OR SHORT TERM DISABILITY PROVIDER:

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE MEDICAL RECORDS DEPARTMENT OF ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, DR. BADY, DR. KURUVILLA, DR. LIU, DR. OTTEN, DR. T. TRAINOR, DR. M. TRAINOR AND/OR DR. YEE.

I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION SHARED IN THE PROCESS OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION AND I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OF MY HEALTH INFORMATION, I CAN RECEIVE FURTHER INFORMATION FROM MY DOCTOR OR HIS STAFF.

UNLESS OTHERWISE REVOKED THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: IF I FAIL TO SPECIFY A DATE, THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE SIGNATURE ON THIS FORM.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

PATIENT PAYMENT POLICY

THANK YOU FOR CHOOSING OUR PRACTICE! WE ARE COMMITTED TO THE SUCCESS OF YOUR MEDICAL TREATMENT AND CARE. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS PART OF THIS TREATMENT AND CARE. FOR YOUR CONVENIENCE, WE HAVE ANSWERED A VARIETY OF COMMONLY-ASKED FINANCIAL POLICY QUESTIONS BELOW. IF YOU NEED FURTHER INFORMATION ABOUT ANY OF THESE POLICIES, PLEASE ASK TO SPEAK WITH A BILLING REPRESENTATIVE OR THE PRACTICE MANAGER.

HOW MAY I PAY?

WE ACCEPT PAYMENT BY CASH, CHECK, AND ATM OR CREDIT CARD WITH A VISA OR MASTERCARD LOGO.

DO I NEED A REFERRAL?

IF YOU HAVE AN HMO PLAN WITH WHICH WE ARE CONTRACTED, YOU NEED A REFERRAL AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN. IF WE HAVE NOT RECEIVED AN AUTHORIZATION PRIOR TO YOUR ARRIVAL AT THE OFFICE, WE HAVE A TELEPHONE AVAILABLE FOR YOU TO CALL YOUR PRIMARY CARE PHYSICIAN TO OBTAIN IT. *IF YOU ARE UNABLE TO OBTAIN THE REFERRAL AT THAT TIME, YOU WILL BE RESCHEDULED.*

WHICH PLANS DO YOU CONTRACT WITH?

PLEASE SEE ATTACHED LIST. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ACCEPT ASSIGNMENT OF INSURANCE BENEFITS. *HOWEVER,* IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY PRIOR TO YOUR FIRST OFFICE VISIT TO DETERMINE YOUR BENEFITS, YOUR CO-PAYMENT, DEDUCTIBLE OR IF YOU REQUIRE AN AUTHORIZATION TO SEE A SPECIALIST.

WHAT IS MY FINANCIAL RESPONSIBILITY FOR SERVICES?

YOUR FINANCIAL RESPONSIBILITY DEPENDS ON A VARIETY OF FACTORS, EXPLAINED ON THE FINANCIAL POLICY OVERVIEW, PLEASE ASK FRONT OFFICE STAFF FOR A COPY.

WHAT IF I REQUIRE FORMS TO BE FILLED OUT BY THE PHYSICIAN (FMLA, DISABILITY, INSURANCE COMPANY FORMS, DMV FORMS) WHAT IS THE PROCESS AND IS THERE A FEE?

WE CANNOT FILL IN FORMS "ON DEMAND". ALL FORMS WILL BE PROCESSED AND COMPLETED IN A 7 DAY PERIOD OF TIME. THE FEE FOR EACH FORM IS $30.00. PLEASE BE ADVISED THAT IF YOUR SHORT/LONG TERM DISABILITY PROVIDER IS NOT RESPONSIBLE FOR REPRODUCTION AND DELIVERY OF MEDICAL RECORDS, THEN PAYMENT REQUESTS WILL BE DIRECTED TO THE PATIENT. COPIES OF ANY IN HOUSE STUDIES WILL BE $30.00 EACH, THE FIRST PATIENT COPY WILL BE PROVIDED FREE OF CHARGE. **COMPLETED PAPERWORK MUST BE PICKED UP FROM OUR OFFICE. PAPERWORK CANNOT BE FAXED.**

WHAT IF I DO NOT HAVE INSURANCE?

PATIENTS WHO DO NOT HAVE INSURANCE ARE REQUIRED TO SPEAK TO MANAGEMENT PRIOR TO RECEIVING TREATMENT AND ON A CASE BY CASE BASIS WILL OFFER A PAYMENT STRUCTURE.

WHAT IS THE PROCEDURE IF I REQUIRE SURGERY?

IF YOUR PHYSICIAN RECOMMENDS SURGERY, YOU WILL BE ESCORTED TO HIS SURGERY COORDINATOR. SHE WILL ANSWER SPECIFIC QUESTIONS ABOUT THE SURGERY SCHEDULING PROCESS, DISCUSS THE PAPERWORK AND TESTS INVOLVED, AND COMPLETE ALL PRE-CERTIFICATION/AUTHORIZATION IF YOUR INSURANCE COMPANY REQUIRES IT. THE SURGERY COORDINATOR WILL REQUEST A PRE-SURGICAL DEPOSIT, THE AMOUNT OF WHICH DEPENDS ON YOUR COVERAGE AND DEDUCTIBLE AMOUNT. A COST ESTIMATE WHICH SHOWS YOUR FINANCIAL RESPONSIBILITY, BASED ON THE BENEFIT LEVELS AND COVERAGE OF YOUR INSURANCE PLAN, WILL BE EXPLAINED BY THE SURGERY COORDINATOR.

WHAT IF MY CHILD NEEDS TO SEE THE PHYSICIAN?

A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY PATIENTS WHO ARE MINORS ON EACH PATIENT'S VISIT. THIS ACCOMPANYING ADULT IS RESPONSIBLE FOR PAYMENT OF THE ACCOUNT, ACCORDING TO THE POLICY OUTLINED ON THE PREVIOUS PAGES.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE FINANCIAL POLICY. I UNDERSTAND THAT CHARGES NOT COVERED BY MY INSURANCE COMPANY, AS WELL AS APPLICABLE COPAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY. I AGREE TO PAY FOR ALL ATTORNEY'S FEES, COURT COSTS AND FILING FEES, INCLUDING CHARGES THAT MAY BE ASSESSED BY OUR COLLECTION AGENCY TO PURSUE COLLECTION OF MY ACCOUNT. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO: ADVANCED ORTHOPEDICS AND SPORTS MEDICINE. I AUTHORIZE ADVANCED ORTHOPEDICS AND SPORTS MEDICINE TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY WHEN REQUESTED, OR TO FACILITATE PAYMENT OF A CLAIM.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

PRIVACY POLICY INFORMATION

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION.

OUR PRIVACY POLICY

ADVANCED ORTHOPEDICS AND SPORTS MEDICINE IS COMMITTED TO KEEPING THE SECURITY AND CONFIDENTIALITY OF PERSONAL INFORMATION THAT YOU PROVIDE TO US. WE TAKE OUR RESPONSIBILITY OF SAFEGUARDING YOUR INFORMATION SERIOUSLY. WE DO NOT SELL OR SHARE CUSTOMER INFORMATION WITH MARKETING GROUPS OUTSIDE OF ADVANCED ORTHOPEDICS AND SPORTS MEDICINE AND ITS AFFILIATE GROUPS.

THIS POLICY COVERS PATIENT INFORMATION, INCLUDING PERSONAL FINANCIAL OR HEALTH INFORMATION ABOUT A PATIENT OR PATIENT RELATIONSHIP. WE ARE DISCLOSING THIS POLICY AS REQUIRED BY FEDERAL AND NEVADA STATE REGULATIONS. IF, AFTER READING THIS NOTICE, YOU HAVE QUESTIONS OR CONCERNS, PLEASE ASK TO SPEAK WITH THE PRACTICE MANAGER.

INFORMATION WE MAY COLLECT

WE COLLECT AND USE SEVERAL KINDS OF INFORMATION IN ORDER TO PROVIDE YOU WITH MEDICAL SERVICES TO BETTER SERVE YOU. THE TYPES OF INFORMATION WE MAY COLLECT CAN BE CATEGORIZED AS FOLLOWS:

- INFORMATION WE RECEIVE FROM YOU ON FORMS; AND
- INFORMATION ABOUT YOUR TRANSACTIONS WITH US OR WITH OUR AFFILIATED THIRD PARTIES
- INFORMATION WE SHARE WITH MEDICAL AFFILIATES
- INFORMATION WE SHARE WITH NON-AFFILIATED THIRD PARTIES
  NON-AFFILIATED THIRD PARTIES ARE COMPANIES NOT CONTROLLED BY ADVANCED ORTHOPEDICS AND SPORTS MEDICINE (NO NON-PUBLIC PERSONAL HEALTH OR FINANCIAL INFORMATION ABOUT PATIENTS OR FORMER PATIENTS IS SHARED WITH THESE NON-AFFILIATED THIRD PARTIES BEYOND WHAT IS NECESSARY TO PROVIDE YOU SERVICES OR AS PERMITTED BY LAW. WE DO NOT SELL ANY OF YOUR INFORMATION TO PERSONS OR ORGANIZATIONS OUTSIDE OF ADVANCED ORTHOPEDICS AND SPORTS MEDICINE).
- OTHER NECESSARY DISCLOSURES OF INFORMATION
  WE MAY ALSO DISCLOSE ANY INFORMATION WE COLLECT WHEN PERMITTED OR REQUIRED BY LAW. FOR EXAMPLE, THIS MAY INCLUDE, BUT IS NOT LIMITED TO, DISCLOSURES RELATED TO A COURT SUBPOENA OR OTHER SIMILAR LEGAL REQUESTS, FRAUD INVESTIGATIONS, OR AN AUDIT OR SECURITY EXAMINATION.

PROTECTING CUSTOMER INFORMATION

WE TAKE EVERY MEASURE TO LIMIT ACCESS TO NON-PUBLIC PATIENT INFORMATION TO THOSE EMPLOYEES OF ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, WHO NEED TO KNOW THE INFORMATION TO PROVIDE SERVICES TO YOU OR ANSWER YOUR QUESTIONS. WE WILL COMPLY WITH REGULATIONS TO PROTECT YOUR NON-PUBLIC PERSONAL INFORMATION.

YOU DO NOT NEED TO SEND ADVANCED ORTHOPEDICS AND SPORTS MEDICINE AN "OPT-OUT" FORM

IT IS NOT NECESSARY FOR PATIENTS TO SEND ADVANCED ORTHOPEDICS AND SPORTS MEDICINE WRITTEN REQUESTS ASKING US NOT TO SHARE THEIR PERSONAL INFORMATION (KNOWN AS AN "OPT-OUT" FORM) BECAUSE: WE DO NOT AND WILL NOT SELL OR SHARE PATIENT INFORMATION FOR MARKETING PURPOSES OUTSIDE ADVANCED ORTHOPEDICS AND SPORTS MEDICINE. NO NON-PUBLIC PERSONAL HEALTH OR FINANCIAL INFORMATION ABOUT PATIENTS OR FORMER PATIENTS IS SHARED WITH NON-AFFILIATED THIRD PARTIES BEYOND WHAT IS NECESSARY (E.G., TO PROCESS CLAIMS) TO PROVIDE YOU WITH MEDICAL SERVICES AS PERMITTED BY LAW.

FOR CASH PAYING PATIENTS ONLY

TO OUR RESPECTED CASH PAYING PATIENTS, PLEASE BE ADVISED OF THE FOLLOWING ESTIMATED AMOUNT FOR SERVICES RENDERED

INITIAL OFFICE CONSULTATION	$254.00
ESTABLISH PATIENT FOLLOW UP VISIT	$154.00
X-RAYS (PER BODY PART)	$50.00
MRI EXTREMITY (I.E. SHOULDER, KNEE, ELBOW, ETC.)	$350.00
MRI SPINE OR HIP(S)	$400.00
FRACTURE CARE (REDUCTION IN-OFFICE)	$1200.00 (APPROXIMATELY)
CORTISONE JOINT INJECTION	$599.00
APPLICATION OF CAST	$600.00-$700.00
PLASMA RICH PROTEIN (PRP) - PER INJECTION	$600.00-$1000.00
PROLOTHERAPY - PER INJECTION	$150.00
INJECTABLE MEDS (I.E. SYNVISC, EUFLEXXA, SUPARTZ)	$750.00-1000.00

THE AFOREMENTIONED AMOUNTS ARE ONLY ESTIMATES AND ARE SUBJECT TO CHANGE BASED ON THE PHYSICIAN'S ASSESSMENT AND THE NATURE OF YOUR INJURY/ILLNESS. OUR OFFICE WILL BE ABLE TO DISCLOSE THE ACCURATE AMOUNT OF YOUR SERVICES AFTER YOUR VISIT WITH THE DOCTOR. IF SURGERY IS WARRANTED, QUOTES FOR THE PROCEDURE(S) WILL BE DISCUSSED AT THE TIME OF YOUR VISIT.

SHOULD YOU HAVE ANY QUESTIONS PRIOR TO OR FOLLOWING YOUR VISIT, PLEASE DO NOT HESITATE TO ASK OUR OFFICE STAFF.

THANK YOU,

ADVANCED ORTHOPEDICS & SPORTS MEDICINE

PLEASE BE SURE TO CHECK OUT THE ADVANCED ORTHOPEDIC AND SPORTS MEDICINE FACEBOOK PAGE AND LIKE OUR PAGE! WE LOVE HAVING OUR PATIENTS AS A PART OF OUR FACEBOOK AND YOU WILL RECEIVE UPDATES AND INFORMATION ABOUT THE PRACTICE!

http://www.facebook.com/#!/AdvancedOrthopedicsLV

AOSM
ADVANCED ORTHOPEDICS & SPORTS MEDICINE

Advanced Orthopedics and Sports Medicine

At Advanced Orthopedics & Sports Medicine, you will experience superior, dedicated care by physicians who hold themselves to a standard of unparalleled excellence.

NAME:_____

Medical disorders: If you have had any of the following, Place Mark inside Circles

- O No Medical History
- O AIDS/HIV
- O **Alcoholism**
- O **Alzheimer's**
- O **Anemia**
- O **Rheumatoid Arthritis**
- O **Asthma**
- O **Blood Clot Leg**
- O **Blood Clot Lung**
- O Stroke
- O Cancer Breast
- O Cancer **Colon**
- O Cancer **Lung**
- O Cancer **Prostate**
- O **COPD**
- O **Depression**
- O **Diabetes**
- O **Drug Abuse**
- O Sleep Apnea
- O Gout
- O Heart Attack
- O High Blood Pressure
- O Hepatitis
- O Kidney Disease
- O Osteoarthritis
- O Seizures
- O Ulcers, Bleeding

O **Other Disease** (list below)

O **Blood thinners (Coumadin, Plavix, aspirin, etc)**

Surgical History: If you have had any of the following, Place Mark inside Circles

- O No Surgical History Reported
- O Carpal Tunnel Left Wrist
- O Arthroscopy Left Elbow
- O Arthroscopy Left Shoulder
- O Arthroscopy Left Ankle
- O Arthroscopy Left Knee
- O Arthroscopy Left Hip
- O Left Hip Replacement
- O Left Knee Replacement
- O Spinal Fusion
- O Other Surgery (list in the box below)
- O Cardiac (Heart)
- O Carpal Tunnel Right Wrist
- O Arthroscopy Right Elbow
- O Arthroscopy Right Shoulder
- O Arthroscopy Right Ankle
- O Arthroscopy Right Knee
- O Arthroscopy Right Hip
- O Right Hip Replacement
- O Right Knee Replacement
- O Laminectomy
- O Fracture Surgery

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- O AIDS/HIV
- O Anemia
- O Blood Clots
- O Cancer
- O Coronary Artery Disease
- O Diabetes
- O Gout
- O Heart Attack
- O Hemophilia
- O Hypertension
- O Kidney Disease
- O Liver Disease
- O Muscle Disease
- O Osteoporosis
- O Rheumatoid Arthritis
- O Osteoarthritis

Mother Medical History

- O AIDS/HIV
- O Anemia
- O Blood Clots
- O Cancer
- O Coronary Artery Disease
- O Diabetes
- O Gout
- O Heart Attack
- O Hemophilia
- O Hypertension
- O Kidney Disease
- O Liver Disease
- O Muscle Disease
- O Osteoporosis
- O Rheumatoid Arthritis
- O Osteoarthritis

Sibling Medical History

- O AIDS/HIV
- O Anemia
- O Blood Clots
- O Cancer
- O Coronary Artery Disease
- O Diabetes
- O Gout
- O Heart Attack
- O Hemophilia
- O Hypertension
- O Kidney Disease
- O Liver Disease
- O Muscle Disease
- O Osteoporosis
- O Rheumatoid Arthritis
- O Osteoarthritis

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Psychological
- O Nervousness
- O Depression
- O Mood Changes

Current Medications

NAME_____ DOB_____ DATE:_____

HEIGHT_____ WEIGHT _____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____

Name:_____ Strength:_____ For:_____ Doctor:_____