BERNARD ONG, M.D.

ORTHOPAEDIC SURGERY

8551 W. LAKE MEAD BLVD • SUITE 251 • LAS VEGAS, NV 89128

Phone: (702) 796-7979 Fax: (702) 456-7979

PATIENT INFORMATION

Last Name: ____ (Jr., Sr., etc.) Sex: M or F Right Handed Left Handed

First name: ____ Middle Initial: ______________________________

Address: ____ Apt./Space: ____________________

City: ____ State: ______________ Zip Code: ______________________

Home Phone: ____________________ Mobile Phone: ____________________ Work Phone: ____________________

Date of Birth: ____________________________ Age:__________ Social Security #: ______________________________

Employer: ____ Occupation: ____________________________

RESPONSIBLE PARTY FOR PAYMENT **SAME AS ABOVE CHECK HERE**

Name: ____ Phone: ____________________

Address: ____ City: __________________ State: _____ Zip: ________

REFERRED BY: ____ Date of Injury: ____________________

Primary Care Physician: ____ Phone: ________________________

Part of Body Being Treated? ____

How Were You Injured? ____

X-Rays Taken Yes No MRI Yes No If Yes, Where? ____

On The Job Injury? Yes No If Yes, Worker's Comp. Insurance Co. _________________________ Claim # ______________

Was this an Auto Accident? Yes No Other If Other Please specify: ____

Do you have an Attorney pertaining to this injury? Yes No If Yes, Attorney's Name: _______________________________

EMERGANCY CONTACT

Name: ____ Phone: ____________________ Relationship: ____________

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Name of Insurance Co. Phone

Name of Insurance Co. Phone

Insurance Co. Claims Address

Insurance Co. Claims Address

Name of Insured Relationship to Patient

Name of Insured Relationship to Patient

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HISTORY FORM

Name: ____

Height: ______________________ Weight: ________________________ Today's Date: __________________________________

CHIEF COMPLAINT

Injured Body Part: _______________________ Please Specify Left or Right: _______________________ Date of Injury: __________________________

Describe what happened: ____

____

Have you been to a physician previously for this problem: Yes No If yes, when? ____

Did you have an MRI: Yes No If yes, where? ____

Allergies:

Medication

Dose

How Long Taken
Side Effects

REVIEW OF SYSTEMS

Are you currently or have you had problems with: Describe all Yes responses

Eyes No Yes
Ears, Nose Throat No Yes
Lungs, Breathing No Yes
Digestion No Yes
Bladder Problem No Yes
Diabetes No Yes
Heart Disease No Yes
High Blood Pressure No Yes
Bleeding Problems No Yes
Balance Problems No Yes
Numbness / Tingling No Yes
Blackouts / Fainting No Yes
Psychological Problems No Yes
Cancer No Yes

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HISTORY FORM

PAST MEDICAL HISTORY

Surgeries / Hospitalization Year Complaint

Have you ever had general anesthesia? No Yes

Any problems with anesthesia? No Yes If yes, please explain ____

SOCIAL HISTORY

Single Married Divorced Separated Widowed

Children No Yes If yes, How many? _________

Do you live alone? No Yes

Exercise: Daily Weekly Monthly Rarely Never

What type of exercise? ____

Are you on a special diet? No Yes Describe: ____

History of substance abuse? No Yes Describe: ____

Do you smoke? No Yes ______ pack(s) per day for ______ year(s)

When did you quit smoking? This year > 1 Year > 5 Years > 10 Years

Drink alcohol? No Yes If yes, how often? Daily 1-2 times per week 1-2 times per month 1-2 times per year

FAMILY HISTORY

Member

Alive?

Age

Health Status or Cause of Death

Father

Yes

No

Mother