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: _____

Email: _____

RESPONSIBLE PARTY FOR PAYMENT

SAME AS ABOVE CHECK HERE ☐

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

REFERRED BY: _____ Date of Injury: _____

Primary Care Physician: _____ Phone: _____

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: _____ Phone: _____

EMERGENCY 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
Policy #	Group #	Policy #	Group #
Insured's Social Security No.	Date of Birth of Insured	Insured's Social Security No.	Date of Birth of Insured

I hereby authorize payment of medical benefits to BERNARD ONG, M.D. for services furnished me. I also authorize the physician to release any information in the course of my examination or treatment. This assignment will remain in effect until revolted by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I hereby consent to and authorize medical treatment, tests, and procedures that my physician deems advisable and necessary based on his judgement.

_____ _____

Patient's Signature or Responsible Party Signature Date

IF YOU ARE COVERED BY MEDICARE, PLEASE COMPLETE THE MEDICARE ASSIGNMENT ON THE FINANCIAL POLICY FORM.

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HISTORY FORM

Name: _____

Height: _____ Weight: _____ Today's Date: _____

CHIEF COMPLAINT

Injured Body Part: _____ Date of Injury: _____

How were you injured? _____

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

X-Rays Taken ☐ Yes ☐ No MRI ☐ Yes ☐ No If Yes, Where? _____

Allergies:	Reaction:

Medication	Dose	How Long Taken

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	
Arthritis	No	Yes	
Polio	No	Yes	
Epilepsy	No	Yes	
HIV	No	Yes	
Hepatitis	No	Yes	
Tuberculosis	No	Yes	
Other	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	Yes	No		
Sister / Brother	Yes	No		
Sister / Brother	Yes	No		
Sister / Brother	Yes	No		
Sister / Brother	Yes	No		

BERNARD ONG, MD

8551 W. Lake Mead Blvd, #251
Las Vegas, NV 89128

Pain Treatment with Opioid Medications: Patient Agreement

I, _____understand and voluntarily agree that (initial each statement after reviewing)

___**I am responsible for my pain medication.** I will keep the medicine safe, secure and out of the reach of children and will not sell this medicine and/or share it with others. My treatment will be stopped otherwise.

___If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

___I will take my medication as instructed and not change the way I take it without first talking to the doctor or his assistant. After 30 days of opioid use, I give consent to possible drug testing, when deemed necessary. Upon 90 days, if opioid medication is still required, I will be referred to a pain specialist.

___I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

___I understand opioids can be effective to treat pain but using them can increase my chances for addiction or overdose. Other methods of treatment include ibuprofen and acetaminophen, as well as physical therapy, massage or acupuncture.

___I will tell the doctor all other medicines that I take and let him know right away if I have a prescription for a new medicine.

___Prescriptions for medications with the potential for misuse, abuse, and addiction are carefully monitored through Nevada Prescription Monitoring Program. Requests for refills of these medications will be evaluated on
a case-by-case basis. If you lie or are otherwise dishonest about your use of these medications, you will be dismissed from the practice and the proper authorities will be notified.

___Opioids may cause sedation, interfere with breathing, urinary and bowel function (constipation), physical dependence, addiction, nausea, vomiting, itching, mood changes, muscle twitching, allergic reactions and injury to the fetus or unborn child in a pregnant woman.

___I understand an opioid antagonist is available without a prescription.

___Risks associated with minors and opioid use can be decreased with adult supervision and monitoring. Possible symptoms of abuse include withdrawal, agitation, paranoia or other aberrant behavior.

___I will use only one pharmacy to get all on my medicines: **Pharmacy name/phone#**_____

_____ _____

Patient Name: Patient Signature

Date_____

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Pain Treatment with Opioid Medications: Patient Agreement

I, _____understand and voluntarily agree that (initial each statement after reviewing)

___I will keep the medicine safe, secure and out of the reach of children.

___If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

___I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

___I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

___I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

___I will sign a release form to let the doctor speak to all other doctors or providers that I see.

___I will tell the doctor all other medicines that I take, and let him know right away if I have a prescription for a new medicine.

___Prescriptions for medications with the potential for misuse, abuse, and addiction are carefully monitored through Nevada Prescription Monitoring Program. Requests for refills of these medications will be evaluated on a case-by-case basis. If you lie or are otherwise dishonest about your use of these medications, you will be dismissed from the practice and the proper authorities will be notified.

___All pain medications that you are allergic to or unable to tolerate must be brought back to the office for destruction before an alternate will be prescribed.

___I will use only one pharmacy to get all on my medicines:

Pharmacy name/phone# _____

___I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____ _____
Patient Name Patient Signature

Date_____