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:

_____

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's 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: _____ 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	
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		