# 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 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 | | |

**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 medications**. 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 my medicines: **Pharmacy name/phone#** _____

_____ _____

Patient Name: Patient Signature

Date_____

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