

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 revoked 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.

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	

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
	Yes	No		
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

ORTHOPAEDIC SURGERY

8551 W Lake Mead Blvd, Suite 251, Las Vegas, NV 89128

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

FINANCIAL POLICY, ASSIGNMENT OF BENEFITS & INSURANCE WAIVER OF LIABILITY

All fees for medical care are based on the usual, reasonable and customary fee charged in this area by physicians of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **This means that you will be expected to pay your insurance co-payment at each visit.** You are responsible for any collection fees if applicable. There will be a \$35.00 charge for any checks returned to our office. There will be a \$20 cancellation fee applied to appointments canceled less than 24 hours prior to you appointment, up to \$100 for appointments requiring additional time.

We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier. Final responsibility of payment of your account rests with you. The exception is for those patients with injuries that are work-related and are covered by Worker's Compensation. These patients are not responsible for their bills unless their claim is denied. You are responsible for providing correct insurance information. Balances and /or payment penalties, as a result of incorrect insurance coverage information provided to us, is patient responsibility. You are also responsible for collection/late fees, if applicable.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions and your insurance carrier determines final payment. If you are scheduled for surgery and an assistant is required, the assistant's fee is in addition to the surgeon's fee. Your insurance will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) of the Social Security Act. This usually applies to DME's (Durable Medical Equipment) which includes slings, splints and braces. If the physician prescribes a DME that your insurance does not cover, you would be responsible for the cost if you accept the DME.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payor of medical benefits to BERNARD ONG, MD., for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize, BERNARD ONG, MD., to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

I hereby consent to and authorize medical treatment, tests and procedures performed in the office that my physician deems advisable and necessary based on his judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

Printed Name

Patient's or Responsible Party's Signature

Date

BERNARD ONG, MD

ORTHOPAEDIC SURGERY

8551 W Lake Mead Blvd, Suite 251, Las Vegas, NV 89128

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

TESTS AND TEST RESULTS

Formulating a diagnosis and treatment plan may require further information. The physician may recommend additional diagnostic testing, such as radiographic studies (i.e. x-ray, MRI, CT scan, Bone Scan etc) and/or lab work.

As a patient, it is important that you obtain the ordered/prescribed tests to optimize your care and prognosis. If the physician orders a test, it is your responsibility to proceed with the test prescribed.

Upon completion of your test, you, the patient, must return to the office within one week to review the test results with the physician. Test results are best reviewed with you in person. The physician/office will not contact you with your results. Test results are only reviewed and discussed in person upon your return visit.

This document confirms your understanding, as the patient, that it is your responsibility to obtain any prescribed/ordered test and follow-up within one week to review the results with the physician. It is not the responsibility of the physician/office to ensure that you proceed with the tests prescribed. Additionally, the physician/office will not be responsible for contacting you with the results. This responsibility rests upon you, the patient.

Signature

Date

Print Your Name

BERNARD ONG, MD

ORTHOPAEDIC SURGERY

8551 W Lake Mead Blvd, Suite 251, Las Vegas, NV 89128

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

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 _____

BERNARD ONG, MD

ORTHOPAEDIC SURGERY

8551 W Lake Mead Blvd, Suite 251, Las Vegas, NV 89128

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

I hereby authorize the release of my medical / health information to the following person(s) and / or entities:

1. _____ (relationship) _____

2. _____ (relationship) _____

3. _____ (relationship) _____

4. _____ (relationship) _____

Print patient's name

Signature / Date

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

I hereby confirm that I have read and received the HIPAA NOTICE OF PRIVACY PRACTICES for the office of Bernard Ong, MD. I also understand that a personal copy of the HIPAA Notice is available upon request.

Print patient's name

Signature / Date

PLEASE INDICATE THE MONTH & YEAR OF YOUR MOST RECENT TEST/VACCINE FOR THE FOLLOWING:

Pneumonia Vaccine _____

Flu Vaccine _____

Colonoscopy _____

Mammogram (women only) _____

Patient Name: _____

Race:

Please circle one:

- | | | | | |
|-------------------------------|------------------|------------------------------|------------------------|-------|
| Asian | Native Hawaiian | Other Pacific Islander | Black/African American | White |
| American Indian/Alaska Native | More than 1 race | Unreported/Refused to report | | |

Ethnicity:

Please circle one:

- | | | |
|-----------------|-----------------------|--------------------------------|
| Hispanic/Latino | Not Hispanic / Latino | Unreported / Refused to report |
|-----------------|-----------------------|--------------------------------|

Preferred Language: _____

It is a federal requirement that we ask the above questions. If you are uncomfortable answering any of these, you have the option to decline by circling "Refused to report"