RANDALL E. YEE, DO
X. NICK LIU, DO
TIMOTHY J. TRAINOR, MD
MICHAEL A. TRAINOR, DO
THOMMAN KURUVILLA, DPM
AI-QUOC HELLER, DPM
GARY MORRIS, MD
ADAM EUDY, DO
PEYMAN DANESH, DPM

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ DOB: _____

ADDRESS: _____ZIP: _____

SSN: _____ HOME PHONE#: _____ CELL PHONE#_____

LANGUAGE: _____ RACE: _____ ETHNICITY: HISPANIC / NOT HISPANIC

HEIGHT: _____ WEIGHT: _____ GENDER: MALE ☐ FEMALE ☐

EMPLOYER: _____ OCCUPATION: _____ WORK#_____

EMAIL: _____

PHARMACY NAME: _____ PHARMACY #: _____

PHARMACY ADDRESS: _____ PCP: _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

FOR XRAY PURPOSES:

ARE YOU PREGNANT OR IS THERE A POSSIBILITY YOU MAY BE PREGNANT? ☐YES ☐NO

WHAT ARE WE SEEING YOU FOR TODAY?

PLEASE CIRCLE RIGHT OR LEFT FOR EACH BOTH PART INVOLVED

1.) _____ RIGHT LEFT

2.) _____ RIGHT LEFT

WHAT DO YOU THINK CAUSED WHAT WE ARE SEEING YOU FOR TODAY? _____

WHAT DATE DID THE PROBLEM START? _____

IF THIS IS AN INJURY, WHERE DID IT OCCUR? _____

DO YOU HAVE AN ATTORNEY FOR THIS INJURY? ☐ YES ☐ NO

ATTORNEY NAME: _____ PHONE #: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

ADDRESS: _____

PHONE: _____

POLICY/ID #: _____

GROUP #: _____

POLICY HOLDER INFORMATION

LAST NAME: _____ M.I. _

FIRST NAME: _____

DOB: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

ADDRESS: _____

PHONE: _____

POLICY/ID #: _____

GROUP #: _____

POLICY HOLDER INFORMATION

LAST NAME: _____ M.I. _

FIRST NAME: _____

DOB: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____

IF PATIENT IS A MINOR PERSON RESPONSIBLE FOR BILL'S

LAST NAME: _____ FIRST: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PH: (___) _____ WORK PH: (___) _____ CELL PH: (___) _____

SSN: _____ GENDER: □ M □ F DATE OF BIRTH: ___/___/_____ AGE: _____

EMERGENCY CONTACT

NAME OF LOCAL FRIEND OR RELATIVE:

LAST NAME: _____ FIRST NAME: _____ RELATIONSHIP: _____

HOME PH: (___) _____ WORK PH: (___) _____ CELL PH: (___) _____

The Above Information Is True to The Best of My Knowledge. I Authorize My Insurance Benefits to Be Paid Directly to The Physician. I Hereby Assign My Healthcare Benefit Payments, To Which I Am Entitled Through My Insurance Company to Advanced Orthopedics and Sports Medicine. This Assignment Is Pursuant to The Employee Retirement Income Security Act (Ersa) As Defined In 29 CFR 2560-503-1, And Applicable State Law, And It Will Remain in The Effect Until Revoked by Me in Writing.

I Understand That I Am Financially Responsible for All the Charges Not Paid by My Insurance. I Hereby Authorize Said Assignee to Release All Information Necessary to Secure the Payment of Said Benefits.

Advanced Orthopedics and Sports Medicine Is Hereby Authorized to Initiate on My Behalf Any Complaints Regarding My Healthcare Benefit Payments or Adverse Benefit Determinations as Defined In 29 CFR 2560-503-1, With the State Insurance Commissioner for A Possible Violation of State Insurance Laws or The Employee Benefits Security Administration and The Secretary of Labor as It Pertains To ERISA, specifically 29 USC 18§§1003(A) And 1144(A).

Advanced Orthopedics and Sports Medicine Is Allowed Full Discovery of Any and All Information, Documentation, Policies, Procedure and Resources Used by My Insurance Company, To Perform an Adverse Benefit Determination, As Defined In 29 CFR 2560-503-1 Of My Covered Health Benefits.

Advanced Orthopedics and Sports Medicine Is Authorized to Represent Me in Any and All Federal Lawsuits Against My Insurance Company Pursuant to the ERISA> A Copy of This Document Is as Valid as The Original.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

HIPAA

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THE FOLLOWING: PHYSICIANS, FAMILY, INSURANCE, SHORT TERM DISABILITY PROVIDERS, ETC.

PATIENT NAME (LAST, FIRST): _____DATE OF BIRTH: _____/_____/_____

NAME OF PARENT OR GUARDIAN IF PATIENT IS A MINOR: _____

IN THE EVENT THAT AOSM MAY NEED TO GIVE YOUR TEST RESULTS OR MEDICAL INFORMATION, MAY *WE:*

_____ LEAVE DETAILED MESSAGE ON AN ANSWERING MACHINE

_____ LEAVE A MESSAGE WITH MY SPOUSE OR FAMILY MEMBER

_____ CALL YOU ON YOUR CELLULAR PHONE; THE PHONE NUMBER IS: (_____) _____

_____ CALL YOU AT WORK; THE PHONE NUMBER IS: (_____) _____

I GIVE ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, DR.YEE, DR. LIU, DR. TIM TRAINOR, DR. SEP BADY, DR. MIKE TRAINOR, DR. THOMMAN KURUVILLA, DR. GARY MORRIS, DR. AI-QUOC HELLER, DR. ADAM EUDY, DR. PEYMAN DANESH AND STAFF THE AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY, FRIENDS, CAREGIVER, PHYSICIAN, INSURANCE AND/OR SHORT-TERM DISABILITY PROVIDER:

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE MEDICAL RECORDS DEPARTMENT OF ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, DR.YEE, DR. LIU, DR. TIM TRAINOR, DR. MIKE TRAINOR, DR. THOMMAN KURUVILLA, DR. GARY MORRIS, DR. AI-QUOC HELLER, DR. ADAM EUDY, DR. PEYMAN DANESH.

I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION SHARED IN THE PROCESS OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION AND I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OF MY HEALTH INFORMATION, I CAN RECEIVE FURTHER INFORMATION FROM MY DOCTOR OR HIS STAFF.

UNLESS OTHERWISE REVOKED THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: IF I FAIL TO SPECIFY A DATE, THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE SIGNATURE ON THIS FORM.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

PRIVACY POLICY INFORMATION

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION.

OUR PRIVACY POLICY

Advanced Orthopedics And Sports Medicine Is Committed To Keeping The Security And Confidentiality Of Personal Information That You Provide To Us. We Take Our Responsibility Of Safeguarding Your Information Seriously. We Do Not Sell Or Share Customer Information With Marketing Groups Outside Of Advanced Orthopedics And Sports Medicine And Its Affiliate Groups.

This Policy Covers Patient Information, Including Personal Financial Or Health Information About A Patient Or Patient Relationship. We Are Disclosing This Policy As Required By Federal And Nevada State Regulations. If, After Reading This Notice, You Have Questions Or Concerns, Please Ask To Speak With The Practice Manager.

INFORMATION WE MAY COLLECT

We Collect And Use Several Kinds Of Information In Order To Provide You With Medical Services To Better Serve You. The Types Of Information We May Collect Can Be Categorized As Follows:

- Information We Receive From You On Forms; And
- Information About Your Transactions With Us Or With Our Affiliated Third Parties
- Information We Share With Medical Affiliates
- Information We Share With Non-Affiliated Third Parties
  Non-Affiliated Third Parties Are Companies Not Controlled By Advanced Orthopedics And Sports Medicine (No Non-Public Personal Health Or Financial Information About Patients Or Former Patients Is Shared With These Non-Affiliated Third Parties Beyond What Is Necessary To Provide You Services Or As Permitted By Law. We Do Not Sell Any Of Your Information To Persons Or Organizations Outside Of Advanced Orthopedics And Sports Medicine).
- Other Necessary Disclosures Of Information
  We May Also Disclose Any Information We Collect When Permitted Or Required By Law. For Example, This May Include, But Is Not Limited To, Disclosures Related To A Court Subpoena Or Other Similar Legal Requests, Fraud Investigations, Or An Audit Or Security Examination.

PROTECTING CUSTOMER INFORMATION

We Take Every Measure To Limit Access To Non-Public Patient Information To Those Employees Of Advanced Orthopedics And Sports Medicine, Who Need To Know The Information To Provide Services To You Or Answer Your Questions. We Will Comply With Regulations To Protect Your Non-Public Personal Information.

YOU DO NOT NEED TO SEND ADVANCED ORTHOPEDICS AND SPORTS MEDICINE AN "OPT-OUT" FORM

It Is Not Necessary For Patients To Send Advanced Orthopedics And Sports Medicine Written Requests Asking Us Not To Share Their Personal Information (Known As An "Opt-Out" Form) Because: We Do Not And Will Not Sell Or Share Patient Information For Marketing Purposes Outside Advanced Orthopedics And Sports Medicine. No Non-Public Personal Health Or Financial Information About Patients Or Former Patients Is Shared With Non-Affiliated Third Parties Beyond What Is Necessary (E.G., To Process Claims) To Provide You With Medical Services As Permitted By Law.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

FINANCIAL AGREEMENT

Thank You for Choosing Advanced Orthopedics for Your Care. Our Physicians Are Committed to The Success of Your Medical Treatment and Care and Realize That Communication Is Vital to The Patient's Well-Being. A Mutual Understanding Is Part of Our Relationship and We Need Your Assistance and Understanding of Our Financial Agreement. It Is Important for You to Understand the Terms of Your Health Insurance Policy. Your Policy Is a Contract Between You and Your Insurance Carrier. Patients Are Responsible for Knowing Which Provider(S) Are Participating with Their Insurance Carrier.

PARTICIPATING INSURANCES: Valid Health Insurance Information Must Be Provided to Us to Ensure Appropriate Reimbursement for Your Care. We Participate with The Most Major Medical Plans. You May Reference Our List of Participating Carriers on Our Website at WWW.AOSMLV.COM. If Your Insurance Does Not Pay 100%, You Will Be Responsible for Any Deductible, Co-Payment, Coinsurance, And Any Non-Covered Services.
NON-PARTICIPATING INSURANCES: Valid Health Insurance Information Must Be Provided to Us to Verify If Your Policy Has "Out-Of-Network" Benefits. You Will Also Be Responsible for Any Balance Over the Reasonable and Customary Charges Arbitrarily Determined by Your Insurance Carrier, In Addition to A Higher Deductible or Co-Insurance Level.
SECONDARY INSURANCE: As A Courtesy to You We Will Bill Your Secondary Insurance. Valid Health Insurance Information Must Be Provided to Ensure Transferring and Billing of Balances After Receiving Your Primary Carrier's Reimbursement.
MEDICARE: As A Participating Provider of Medicare Part B, We Will Only Bill You Your Medicare Deductible and Coinsurance If You Do Not Have Secondary/Supplemental Insurance. Note: You Will Be Informed of Any Services Which Are Not Covered by Medicare Prior To Services Being Rendered. If You Choose to Have the Services Rendered, Your Signature Will Be Required Stating You Accept the Financial Responsibility for These Services.
WORKERS COMPENSATION / AUTO INSURANCE: We Will Submit Claims to A Valid Carrier. If You Have Health Insurance, You Will Be Required to Provide the Information to Us in Case Your WC/Auto Benefits Are Denied or Exhausted. All Remaining Balances or Denied Services Will Be Your Responsibility.
REFERRALS: It Is Your Responsibility to Bring Any Required Referral for Treatment to Your Visit. If You Do Not Have the Required Referral Your Appointment Will Be Rescheduled.
Co-Pays: Co-Pays Are Due at The Time of Service.
SELF-PAY: If You Do Not Carry Insurance - Payment Is Expected at Time of Service for Any Incurred Charges. If Surgery Is Required, Surgery Will Not Be for Scheduled Until Financial Arrangements Have Been Made with Our Billing Coordinator/Medical Staff.
BALANCE: All Patient Balances (After Insurance Has Been Processed) Will Be Due in Full After 30 Days Unless Payment Arrangements Have Been Established with Our Billing Coordinator.
COLLECTIONS: Any Patient That Has Been Placed in Collections Must Pay Any Outstanding Balances Owed Along with The Collection Agency Fee Before an Appointment Will Be Scheduled.
FORM COMPLETION: Most Forms Are Completed Within 7-10 Business Days. A Payment Of $33 Per Form Is Required When Picking Up Forms. PLEASE BE ADVISED THAT IF YOUR SHORT/LONG TERM DISABILITY PROVIDER IS NOT RESPONSIBLE FOR REPRODUCTION AND DELIVERY OF MEDICAL RECORDS, THEN PAYMENT REQUESTS WILL BE DIRECTED TO THE PATIENT. Copies Of Any In-House Studies Will Be **$33.00** Each. THE FIRST PATIENT COPY WILL BE PROVIDED FREE OF CHARGE.
COMPLETED PAPERWORK MUST BE PICKED UP FROM OUR OFFICE, PAPERWORK CANNOT BE FAXED.
PAYMENT PLANS: Our Office Will Be Happy to Work with You in Order to Pay Any Balance Due to Our Practice.
PAYMENT METHODS: We Accept Cash, Check, American Express, Mastercard, Visa and Discover. You May Also Pay Your Bill Online at WWW.AOSMLV.COM.
REFUNDS: Refunds Are Issued to The Appropriate Party. Patient Refunds Will Not Be Processed Until All Active or Past Due Charges Are Paid in Full.

By Signing This Document, I _____, Have Fully Read and Understand the Financial Agreement of Advanced Orthopedics. I Hereby Consent to Allow Advanced Orthopedics to Reach Me Via: (Check All That Apply)
___Home Phone (_____) _____-_____Cell Phone (_____) _____-_____Work Phone (_____) _____-_____

I Will Cooperate with The Billing Department of Advanced Orthopedics to Ensure Payment for My Services. I Understand That I Will Be Responsible for Any Cost(S) Associated with The Collection of My Account If I Default on This Agreement. I Understand That the Terms of This Financial Agreement May Be Amended at Any Time Without Prior Notification to Me, The Patient. In The Event That the Patient Is a Minor, I Am the Parent And/or Legal Guardian of Said Patient and Agree That I Am Responsible for All Services Rendered to The Patient Herein.

_____
PRINTED PATIENT OR GUARDIAN NAME

_____ _____
PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

ADVANCED
Orthopedics & Sports Medicine
EXPERTISE MEETS EXCELLENCE

Randall E. Yee, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Sports Medicine

Gary Morris, M.D.
Board Certified Orthopedic Surgeon
Fellowship Trained in Foot & Ankle

Michael Trainor, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Spine Surgeon

X. Nick Liu, D.O.
Board Certified Orthopedic Surgeon
Fellowship Trained Sports Medicine

Ai-Quoc Heller, D.P.M.
American Board of Multiple Specialties in Podiatry

Adam Eudy, D.O.
Orthopedic Surgeon
Fellowship Trained in Adult Hip & Knee Replacement & Reconstruction

Timothy J. Trainor, M.D.
Board Certified Orthopedic Surgeon
Board Certified Orthopedic Sports Medicine

Thomman Kuruvilla, D.P.M.
American Board of Multiple Specialties in Podiatry and Board Certified Foot & Ankle Surgery.

Peyman Danesh, D.P.M.
Diplomate, American Board of Podiatric Medicine
Reconstructive Rearfoot & Ankle Surgery

FOR CASH PAYING PATIENTS ONLY

TO OUR RESPECTED CASH PAYING PATIENTS, PLEASE BE ADVISED OF THE FOLLOWING **ESTIMATED** AMOUNT FOR SERVICES RENDERED

INITIAL OFFICE CONSULTATION	$330.00
ESTABLISH PATIENT FOLLOW UP VISIT	$198.00
X-RAYS (PER BODY PART I.E. SHOULDER, KNEE, ELBOW, ETC)	$55.00
X-RAYS (PER BODY PART I.E. SPINE)	$82.50
MRI EXTREMITY (I.E. SHOULDER, KNEE, ELBOW, ETC.)	$350.00
MRI SPINE OR HIP(S)	$450.00
MRI ARTHROGRAM	$1200.00
FRACTURE CARE (REDUCTION IN-OFFICE)	$1320.00 (APPROXIMATELY)
CORTISONE JOINT INJECTION	$737.00
BILATERAL CORTISONE INJECTION	$979.00
CORTISONE JOINT INJECTION ESTABLISHED PATIENT	$605.00
BILATERAL CORTISONE INJECTION ESTABLISHED PATIENT	$847.00
APPLICATION OF CAST	$715.00
REPLACEMENT OF CAST	$110.00
PLASMA RICH PROTEIN (PRP) - PER INJECTION	$750.00-$1500.00
INJECTABLE MEDS 1ST INJ (I.E. SYNVISC, EUFLEXXA, ORTHOVISC)	$1522.00
INJECTABLE MEDS 2ND INJ (I.E. SYNVISC, EUFLEXXA, ORTHOVISC)	$850.00
INJECTABLE MEDS 3RD INJ (I.E. SYNVISC, EUFLEXXA, ORTHOVISC)	$850.00
FMLA/DISABILITY/DMV FORM(S)	$33.00

THE AFOREMENTIONED AMOUNTS ARE ONLY **ESTIMATES** AND ARE SUBJECT TO CHANGE BASED ON THE PHYSICIAN'S ASSESSMENT AND THE NATURE OF YOUR INJURY/ILLNESS. OUR OFFICE WILL BE ABLE TO DISCLOSE THE ACCURATE AMOUNT OF YOUR SERVICES AFTER YOUR VISIT WITH THE DOCTOR. IF SURGERY IS WARRANTED, QUOTES FOR THE PROCEDURE(S) WILL BE DISCUSSED AT THE TIME OF YOUR VISIT.

SHOULD YOU HAVE ANY QUESTIONS PRIOR TO OR FOLLOWING YOUR VISIT, PLEASE DO NOT HESITATE TO ASK OUR OFFICE STAFF.

THANK YOU

Patient Name:_____ DOB:_____ Date:_____

Height:_____ Weight:_____

Medical disorders: If you have had any of the following, Place Mark inside Circles

- ○ No Medical History
- ○ AIDS/HIV
- ○ Alcoholism
- ○ Alzheimer's
- ○ Anemia
- ○ Rheumatoid Arthritis
- ○ Asthma
- ○ Blood Clot Leg
- ○ Blood Clot Lung
- ○ Other Disease (list below)
- ○ Stroke
- ○ Cancer Breast
- ○ Cancer Colon
- ○ Cancer Lung
- ○ Cancer Prostate
- ○ COPD
- ○ Depression
- ○ Diabetes
- ○ Drug Abuse
- ○ Blood thinners (Coumadin, Plavix, aspirin, etc)
- ○ Sleep Apnea
- ○ Gout
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Hepatitis
- ○ Kidney Disease
- ○ Osteoarthritis
- ○ Seizures
- ○ Ulcers, Bleeding

Surgical History: If you have had any of the following, Place Mark inside Circles

- ○ No Surgical History Reported
- ○ Carpal Tunnel Left Wrist
- ○ Arthroscopy Left Elbow
- ○ Arthroscopy Left Shoulder
- ○ Arthroscopy Left Ankle
- ○ Arthroscopy Left Knee
- ○ Arthroscopy Left Hip
- ○ Left Hip Replacement
- ○ Left Knee Replacement
- ○ Spinal Fusion
- ○ Other Surgery (list in the box below)
- ○ Cardiac (Heart)
- ○ Carpal Tunnel Right Wrist
- ○ Arthroscopy Right Elbow
- ○ Arthroscopy Right Shoulder
- ○ Arthroscopy Right Ankle
- ○ Arthroscopy Right Knee
- ○ Arthroscopy Right Hip
- ○ Right Hip Replacement
- ○ Right Knee Replacement
- ○ Laminectomy
- ○ Fracture Surgery

Patient Name:_____ DOB:_____ Date:_____

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Mother Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Sibling Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Patient Name:_____ DOB:_____ Date:_____

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Psychological
- O Nervousness
- O Depression
- O Mood Changes

Patient Name:_____ DOB:_____ Date:_____

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box

MEDICATION FORM

Name: _____

DOB: _____

Please list your medications (include over-the-counter medications as well as supplements and herbal remedies), the dosage, and how often you take each.

	Home Medications, Supplements, and Herbal Remedies	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			