Orthopedic & Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.
7281 W Sahara Suite #110 Las Vegas, NV 89117
Ph: 702.947.7790 Fax: 702.947.7792

New Patient Forms- Completion Instructions

Welcome to our practice.

The following forms are for new patients who have never completed intake forms for our office.
The documents are dynamic, you can type directly on them. Once completed, you will need to print them and sign in all required areas. (Documents cannot be submitted electronically due to the privacy act).
Please bring all fully completed and signed forms with you to your scheduled appointment.
If you are a new patient with a Work Comp injury, please complete the Work Comp New Patient Forms. (Do Not Complete these standard information forms. Instead, please choose the Work Comp New Patient Information Forms, just below this selection under "Medical Forms" on the website).
If you have any questions regarding these forms, please call our office at: 702.947.7790 and someone will assist you.
If you find errors in the dynamics of the forms, please let us know. We are always looking to improve our documents for ease of completion.

We look forward to seeing you at your appointment.

Sincerely,
Randa Bascharon, D.O.
Randa Bascharon, D.O. and Staff

Orthopedic & Sports Medicine Institute Of Las Vegas
Randa Bascharon, D.O., Inc.
Ph: 702.947.7790 Fax: 702.947-7792

IMPORTANT INFORMATION FOR OUR PATIENTS

AFTER HOURS INFORMATION:

If you have an emergency dial 911.
If you need to speak to the physician after hours, you can call our office number listed above. Let the answering service know you are one of our regular patients and where you are calling from. You will be directed to the physician on call who will be able to assist you. Our office rotates call with other local orthopedic physicians and there is one on call every day.

APPOINTMENT INFORMATION:

If you are arrive late for your scheduled appointment we may need to reschedule your appointment in order to accommodate the patients who are scheduled for that time slot. Please refer to our office "No Show" policy for information and policy regarding appointments not cancelled at least 24 hours in advance.

FORMS:

We cannot complete forms “on demand”. All forms will be processed and completed within a 7 day time period. The fee for each form is $15.00 to $50.00, and may not be covered by your insurance. You will be expected to pay this fee at the time of completion.

CASTING INFORMATION:

Patients with fiberglass casting: DO NOT GET YOUR CAST WET!
If this does occur, please contact our office as soon as possible for a cast change. (Splashing a few drops of water on the outside of the cast is not a problem, but the padding against your arm should not become damp or wet).

PRESCRIPTION REFILLS:

If you need prescription refills, we ask that you plan at least 48 hours in advance.
Contact your pharmacy first (the one where the prescription was last filled). Have your prescription information ready for them when you call. The prescription number is helpful, and the name and strength of drug. It is not necessary to call our office first for refills. Please have your pharmacy fax over a refill request to 947-7792. If you are changing your pharmacy, you may have to contact us first as this will then be considered a new prescription. Check with your pharmacy as they may be able to “transfer” the prescription to your new pharmacy of choice.

**Please keep this document for future reference.

Orthopedic and Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

Thank you for choosing our practice! We are committed to the success of your Medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or our Practice Manager.

How may I pay?

We accept payment by cash, check, ATM with Visa or MasterCard logo, VISA, & MasterCard.
Please be advised Returned checks are subject to an additional fee of $25.00.

Do I need a referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, your appointment will need to be rescheduled.

Which Plans Do You Contract With?

Your insurance policy is a contract between you and your insurance company. We accept assignment of Insurance benefits. However, it is your responsibility to call your insurance company prior to your first office visit to determine your benefits, your co-payment, co-insurance, deductible or if you require an authorization to see a specialist. We do contract with many insurance companies. However this changes frequently.

What Is My Financial Responsibility For Services?

Patients are responsible for all charges from the date they are charged. Patients who have insurance companies with whom we are contracted specialists will be responsible for all insurance directed copays, deductibles and co-insurance as per your contract.

What If I require forms to be filled out by the physician (FMLA, disability, insurance company forms, and DMV forms) what is the process and is there a fee?

We cannot complete forms "on demand". All forms will be processed and completed within a 7 day period of time. The fee for each form is $15.00 to $50.00, and may not be covered by your insurance. You will be billed for this fee.

What if I do not have insurance?

Patients who do not have insurance are required to speak to management prior to receiving treatment and on a case by case basis may be offered a payment structure.

Copays, Deductible and Co-insurance: All insurance copays, deductibles and co-insurances are due at the time of service.

Insurance Billing and Balances: Your insurance is a contract between you & your insurance company. We may bill your insurance for you. It is our goal to help you receive the maximum allowable benefits. Not all services are a "covered" benefit. It is your responsibility to be familiar with the benefits and restrictions provided by your plan. Contact your insurance carrier or consult your plan coverage and Provider directory to be familiar with your coverage and Providers of care.
You will receive a statement from our office once a month, regardless of insurance / patient balance. All charges are patient responsibility from the day of charge. Please contact your insurance company when claims have not been processed within 30 days. We will gladly discuss your proposed treatment plan and answer questions related to charges for those services.

_____
INITIAL

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

Collection processes: Accounts with unpaid balances after 90 days may be turned over to a Collection Agency for assistance in collection. If this occurs, you will be responsible for all agency fees, legal fees and court costs incurred as a result.

_____
INITIAL

Authorization for Use or Disclosure of Health Information Relating to Payment for Services Rendered by Dr. Randa Bascharon, DBA: Orthopedic & Sports Medicine Institute of Las Vegas.

I hereby authorize Dr. Randa Bascharon,(*Medical Provider) DBA: Orthopedic & Sports Medicine Institute of Las Vegas, and its vendors and service providers involved in collection and processing of payments for services delivered to me by Medical Provider ("Vendors") to disclose health information (including my name and financial account information) records concerning:

_____
Patient name Patient address, city state zip

TO: Any and all vendors or subcontractors to Vendors that assist in the collection and processing of payments for services provided by Medical Provider to Patient.
FOR THE PURPOSE OF: Collection and processing of payment for services provided by Medical Provider to Patient.
REVOCATION: I understand that I may revoke this authorization at any time by notifying Medical Provider in writing at 7281 W Sahara Ave. Ste 110, Las Vegas, NV 89117. I understand that my revocation will not affect actions taken by Medical Provider or any Vendor prior to its receipt.
I understand that I have a right to receive a copy of this authorization.

_____
Patient / Guarantor signature Date Time

Surgery & Outside referrals (including but not limited to: Hospitals & surgery centers, Other physicians / specialists, Physical therapy, Radiology services & Laboratories.

If your physician recommends surgery, you will be referred to his / her surgery coordinator. The surgery coordinator will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification / authorization if your insurance company requires it. The surgery coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the surgery coordinator or billing specialist.
If your physician refers you to an outside facility for services that may include, but are not limited to: surgery, any therapy, another physician, labs, or x-ray, we may be required to provide demographic and / or medical information to that facility prior to your appointment with them.
I authorize the release of any medical or demographic information necessary to complete the process of the referral to any outside Medical service. _____
Signature of patient / guardian Date

Dispensing of Durable Medical Equipment: Durable Medical Equipment may be billed by this office or an outside service. I authorize the release of any medical information necessary to process the health insurance claim for this service. I request direct payment be made to Randa Bascharon, D.O., Orthopedic and Sports Medicine Institute of Las Vegas, or other vendor who may supply & bill for the DME. _____
Signature of patient / guardian Date

FINANCIAL RESPONSIBILITY & AUTHORIZATIONS FORM

Automobile Accident: I, the undersigned patient / guardian, hereby direct my Auto Insurance medical payments, Personal Injury Protection and / or Health Insurance benefits carrier / s to make payment for medical supplies and services directly to Randa Bascharon, D.O, Inc, Orthopedic and Sports Medicine Institute of Las Vegas.

_____

Signature of patient / guardian Date

Authorization to View Medication Information / history: Our office is currently utilizing an electronic system for prescribing, refilling and tracking medications called: "SureScripts". It is a community database for accessing and adding patient prescription and medication information and history. SureScripts is a valuable tool for helping to ensure that your medications are effective and do not have interactions with other medications being prescribed.

Your prescription will be electronically prescribed to a SureScript pharmacy and should be ready for pick up by the time you leave our office.

Please be aware that some medications will still have hand written requirements and therefore will not be eligible for this new electronic method.

By signing below, you are aware and are authorizing our office personnel to view your medication history available through the SureScript database or any other electronic database being utilized by our practice.

_____

Signature of patient / guardian Date

Financial Agreement and Authorization:

I have read, understand, and agree to the above Financial Policy. I understand that all charges, including applicable co-payments, co-insurances and deductibles, are my responsibility. I agree that any balance not paid by insurance will be paid by me.

I agree to pay for all attorney's fees, court costs and filing fees, including charges that may be assessed by our collection agency to pursue collection of my account.

I authorize my insurance benefits, auto medical payments or attorney settlement be paid directly to Randa Bascharon, D.O. Inc, Orthopedic & Sport Medicine Institute of Las Vegas.

I authorize Randa Bascharon, D.O. Inc, Orthopedic & Sport Medicine Institute of Las Vegas, to release pertinent medical information to my insurance company, automobile medical insurance company or attorney when requested to facilitate payment of a claim. A photocopy of this executed document shall be sufficient in law as any original.

_____

Signature of Patient or Guardian Printed Name of Patient Date

Printed Name of Guardian _____ Guardians relationship to patient: _____

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Patient No Show Policy & Procedure

If you are unable to keep your appointment, you are required to provide a 24 hour notice of cancellation.

Failure to cancel your appointment with a 24 hour notice will result in a phone call to the number on file and a "NO SHOW" warning letter mailed to the address on file. To assist you in keeping your appointment, you will receive a reminder call from our automated system.

If there is a subsequent "NO SHOW" appointment, your account may be charged 25.00 for which you are entirely financially responsible. It is not covered by your insurance and will not be billed to insurance. You will need to pay the "NO SHOW" fee in full to obtain any further appointments with our office.

We hope that all of our patients get the care they need and show consideration by notifying us in advance of the inability to keep an appointment so that another patient may have that time slot.

We are very concerned when you miss appointments that you are not receiving the necessary medical care required for your injury or illness.
Please call if you are experiencing any problems. We value you as a patient.

ATTN: ACCESS TO HEALTHCARE NETWORK PATIENTS: YOU WILL SIGN BELOW ACKNOWLEDING THAT YOUR AHN MEMBER AGREEMENT REGARDING APPOINTMENT NO SHOW POLICIES WILL SUPERCEDE THIS DOCUMENT. PLEASE REFER TO YOUR AHN AGREEMENT FOR THAT INFORMATION.

_____

Patient printed name Date

_____

Signature of patient / guardian

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Orthopedic and Sports Medicine Institute Of Las Vegas
Randa Bascharon, D.O., Inc.
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Ph: 702.947.7790 Fax: 702.947-7792

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICER Phone email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Orthopedic and Sports Medicine Institute Of Las Vegas
Randa Bascharon, D.O., Inc.
Ph: 702.947.7790 Fax: 702.947-7792

HIPAA NOTICE OF PRIVACY PRACTICES

(This page will be retained in your medical records at Orthopedic and Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O. Inc.)

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Orthopedic & Sports Medicine Institute, Dr. Randa Bascharon's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

OUR MEDICARE COMPLIANCE PLEDGE

Our office is fully committed to compliance with all Medicare laws, rules and regulations. If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Compliance Officer.

_____ _____

PRINT PATIENT NAME *SIGNATURE PATIENT/GUARDIAN*

DATE _____

Orthopedic and Sports Medicine Institute Of Las Vegas
Randa Bascharon, D.O., Inc.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND / OR CAREGIVERS

****

PATIENT NAME: _____

NAME OF PARENT / GUARDIAN (IF PATIENT IS MINOR)_____

In the event Orthopedic & Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O., Inc. may need to give your test results or medical information, may we.....
Check all that apply.

_____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, _____whose date of birth is:_____, hereby give

Orthopedics and Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O., Inc. and staff, the authorization to disclose my protected health information to the following family, friends, and / or caregiver:

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 Orthopedic and Sports Medicine Institute of Las Vegas, Randa Bascharon, D.O., Inc.

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.

_____/_____
SIGNATURE OF PATIENT DATE

_____/_____
SIGNATURE OF PARENT / GUARDIAN (IF PATIENT IS A MINOR) DATE

_____/_____/_____
NAME OF WITNESS SIGNATURE OF WITNESSS DATE
(Our office staff will sign in the witness area)

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Authorization to View Medication Information

Our office is currently utilizing an electronic system for prescribing, refilling and tracking medications called : "SureScripts". It is a community database for accessing and adding patient prescription and medication information and history. SureScripts is a valuable tool for helping to ensure that your medications are effective and do not have interactions with other medications being prescribed.
Your prescription will be electronically prescribed to a SureScript pharmacy and should be ready for pick up by the time you leave our office.
Please be aware that some medications will still have hand written requirements and therefore will not be eligible for this new electronic method.

By signing below, you are aware and are authorizing our office personnel to view your medication history available through the SureScript or any other electronic database being utilized by our office.

Patient name:

Date of Birth:

_____

Signature of patient/ guardian Date

_____

Printed Name if guardian/responsible party is signing for patient. Relationship to patient

Orthopedic & Sports Medicine Institute of Las Vegas
RANDA BASCHARON, D.O., INC.

WORKMAN'S COMPENSATION INJURY

WE MUST HAVE COMPLETE AND ACCURATE INFORMATION IN ALL SECTIONS!
(PLEASE ASK FOR ASSISTANCE WITH PHONE BOOKS, OR PHONE CALLS IF NEEDED FOR ADDRESSES AND PHONE NUMBERS.)

HOW WERE YOU REFERRED TO OUR OFFICE?

☐ OTHER PHYSICIAN: FIRST NAME_____ LAST NAME _____ ADDR_____ CITY_____ STATE_____
☐ URGENT CARE / EMERG ROOM: NAME OF FACILITY _____ ADDR_____ CITY_____ STATE_____
☐ INSURANCE COMPANY REFERRED: NAME OF INS CO_____ AUTH#_____ REPRESENTATIVE NAME_____
☐ FRIEND OR RELATIVE: FIRST NAME_____ LAST NAME _____ Are they patients in this practice? ☐ YES ☐ NO

PATIENT: LAST NAME_____ FIRST_____ MIDDLE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE: _____ CELL PH: _____ OTHER PH: _____

SSN_____ SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH:_____/_____/_____ AGE_____

EMAIL ADDRESS _____
DO YOU AGREE TO RECEIVE EMAIL REGARDING YOUR FINANCIAL ACCOUNT WITH OUR OFFICE ? ☐ YES ☐ NO
DO YOU AGREE TO RECEIVE NEWLETTERS OR OTHER CORRESPONDENCE FROM OUR OFFICE VIA EMAIL? ☐ YES ☐ NO
DO YOU AGREE TO RECEIVE EMAIL REGARDING YOUR APPOINTMENTS ? ☐ YES ☐ NO

NAME OF EMPLOYER AT TIME OF INJURY_____ DEPT:_____

EMPLOYER (AT TIME OF INJURY)
ADDRESS_____ CITY_____ STATE_____ ZIP_____ PHONE #: _____

DATE OF INJURY_____ / MO_____ DAY / _____ / YR DATE LAST WORKED FOR THIS EMPLOYER: _____ / MO_____ / DAY_____ / YR
BODY PART / S INVOLVED ☐ RIGHT ☐ LEFT_____
EXPLAIN HOW INJURY OCCURRED_____

NEW INJURY:

DID YOU / HAVE YOU, REPORTED THE INJURY TO YOUR SUPERVISOR? ☐ YES ☐ NO
IF YES, SUPERVISORS NAME:_____ DATE REPORTED _____ / MO_____ DAY / _____ / YR
DO YOU HAVE A COMPLETED C-4 FORM? ☐ YES ☐ NO

OLD INJURY : HAVE YOU SEEN ANOTHER PHYSICIAN FOR THIS INJURY? ☐ YES ☐ NO

NAME OF DR: _____
ADDR_____ CITY_____ STATE_____ ZIP_____
IS THIS PHYSICIAN YOUR "CURRENT TREATING PHYSICIAN? ☐ YES ☐ NO IF NO, LIST NAME OF CURRENT TREATING PHYSICIAN
NAME OF DR: _____
ADDR_____ CITY_____ STATE_____ ZIP_____
WHAT IS THE REASON YOU ARE SEEING US TODAY? ☐ ANOTHER OPINION? ☐ CHANGE IN TREATING DR?
☐ OTHER REASON : EXPLAIN _____

INSURANCE:

NAME OF CLAIMS ADMINISTRATOR: (INDUSTRIAL INS CO) _____

ADDRESS:(TO MAIL CLAIMS)_____ CITY_____ STATE_____ ZIP_____

CLAIM# _____ ADJUSTORS NAME:_____ PH_____ EXT # _____

The above information is true to the best of my knowledge. I authorize my insurance benefits or attorney settlement payments to be paid directly to O orthopedic & Sports Medicine Institute of Las Vegas, Dr. Randa Bascharon D.O., Inc. I understand that I am financially responsible for any balance. I also authorize Orthopedic & Sports Medicine Institute of Las Vegas, Dr. Randa Bascharon D.O., Inc. or insurance company or attorney to release any information required to process my claims.

X
_____ / _____
PATIENT OR GUARDIAN SIGNATURE *DATE*

Orthopedic & Sports Medicine Institute of Las Vegas
Randa Bascharon, D.O. Inc.

NEW PATIENT MEDICAL HISTORY

PATIENT NAME _____ DATE TODAY_____

CHIEF COMPLAINT/S: _____

DATE OF INJURY_____ IF NOT INJURY, DATE OF ONSET OF SYMPTOMS:_____

PRIMARY CARE PHYSICIAN:_____REFERRING PHYSICIAN:_____

DATE OF BIRTH_____AGE TODAY_____HEIGHT_____ WEIGHT_____

IS YOUR INJURY/S RELATED TO:
☐ AUTO ACCIDENT ☐ WORK ACCIDENT ☐ SCHOOL ACCIDENT ☐ ATHLETIC ACCIDENT: WHERE_____
☐ NO INJURY – ONSET OF SYMPTOMS ONLY ☐ OTHER: EXPLAIN_____

A): CHECK BOX FOR ANY DISEASE WITH WHICH YOU WERE PREVIOUSLY DIAGNOSED:

☐ AIDS/HIV	☐ DEPRESSION	☐ HYPERTENSION
☐ ALCOHOLISM	☐ DIABETES	☐ KIDNEY DISEASE
☐ ALZHEIMERS	☐ DRUG ABUSE	☐ OSTEOARTHRITIS
☐ ANEMIA	☐ ELEVATED CHOLESTROL	☐ OSTEOPOROSIS
☐ ARTHRITIS	☐ EYE DISEASE	☐ PACEMAKER
☐ ASTHMA	☐ FIBROMYALGIA	☐ SEIZURES
☐ BLEEDING DISORDERS	☐ GI REFLUX (GERDS)	☐ SLEEP APNEA
☐ BLOOD CLOTS	☐ GOUT	☐ STROKE
☐ CANCER	☐ HEART DISEASE	☐ THYROID DISEASE
☐ COPD	☐ HEPATITIS	☐ ULCERS

ARE YOU: ☐ RIGHT HANDED ☐ LEFT HANDED ☐ AMBIDEXTROUS (BOTH)

B): LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER DRUGS, VITAMINS, SUPPLEMENTS AND THEIR USE

DRUG NAME	DOSE/STRENGTH	FREQUENCY	PRESCRIBING DR	REASON

(*LIST ANY ADDITIONAL MEDICATIONS ON LAST PAGE: ADDITIONAL INFORMATION.)

C): ALLERGIES TO MEDICATION: ☐ NONE KNOWN ☐ CODEINE ☐ PENICILLIN ☐ IODINE ☐ SULFA ☐ DEMEROL

OTHER DRUG ALLERGIES NOT LISTED ABOVE: _____
LIST TYPE OF REACTION TO EACH _____
_____

OTHER ALLERGIES: ☐ LATEX ☐ ADHESIVE TAPE ☐ CATS ☐ DOGS ☐ HAYFEVER ☐ OTHER : PLEASE LIST_____
_____

FOOD ALLERGIES: ☐ PEANUTS ☐ SOY ☐ MILK/DAIRY ☐ GLUTEN ☐ EGG ☐ SEAFOOD ☐ OTHERS PLEASE LIST: _____
_____

(*LIST ANY ADDITIONAL ORTHOPEDIC SURGERIES ON LAST PAGE: ADDITIONAL INFORMATION.)

D): ORTHOPEDIC SURGERIES: ☐ NO ORTHOPEDIC SURGERIES

☐ RIGHT ☐ LEFT BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
☐ RIGHT ☐ LEFT BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
☐ RIGHT ☐ LEFT BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
☐ RIGHT ☐ LEFT BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____

ORTHOPEDIC REPLACEMENTS: ☐NO ORTHOPEDIC REPLACEMENTS
☐RIGHT ☐LEFT BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
☐RIGHT ☐LEFT BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
(LIST ANY ADDITIONAL ORTHOPEDIC SURGERIES ON LAST PAGE: ADDITIONAL INFORMATION.)

OTHER SURGERIES (ANY) : ☐NO OTHER SURGERIES
BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
BODY PART _____ MO/YR_____ SURGEON_____HOSPITAL_____
(LIST ANY ADDITIONAL SURGERIES ON LAST PAGE: ADDITIONAL INFORMATION.)

FRACTURES/BROKEN BONES: ☐NO FRACTURES/BROKEN BONES
BODY PART _____ MO/YR_____DR: _____ ☐CASTED ☐SURGERY
BODY PART _____ MO/YR_____DR: _____ ☐CASTED ☐SURGERY
BODY PART _____ MO/YR_____DR: _____ ☐CASTED ☐SURGERY
(LIST ANY ADDITIONAL FRACTURES ON LAST PAGE: ADDITIONAL INFORMATION.)

E): FAMILY HISTORY: HAVE ANY OF YOUR FAMILY NMEMBERS EVER BEEN DIAGNOSES WITH THE FOLLOWING: (INCLUDE: SPOUSE, SON, DAUGHTER, FATHER, MOTHER, SISTER, BROTHER, GRANDFATHER, GRANDMOTHER- LIST PATERNAL OR MATERNAL)
IF YES, WHO?

☐ AIDS/HIV _____	☐ DEPRESSION _____	☐ HYPERTENSION _____
☐ ALCOHOLISM _____	☐ DIABETES _____	☐ KIDNEY DISEASE _____
☐ ALZHEIMERS _____	☐ DRUG ABUSE _____	☐ OSTEOARTHRITIS _____
☐ ANEMIA _____	☐ ELEVATED CHOLESTROL _____	☐ OSTEOPOROSIS _____
☐ ARTHRITIS _____	☐ EYE DISEASE _____	☐ PACEMAKER _____
☐ ASTHMA _____	☐ FIBROMYALGIA _____	☐ SEIZURES _____
☐ BLEEDING DISORDERS _____	☐ GI REFLUX (GERDS) _____	☐ SLEEP APNEA _____
☐ BLOOD CLOTS _____	☐ GOUT _____	☐ STROKE _____
☐ CANCER _____	☐ HEART DISEASE _____	☐ THYROID DISEASE _____
☐ COPD _____	☐ HEPATITIS _____	☐ ULCERS _____
☐ LUPUS _____	☐ OTHER AUTO IMMUNE DISORDER_____	

DO YOU HAVE CHILDREN? ☐YES ☐NO AGES AND SEX_____

F): SOCIAL HISTORY:
OCCUPATION: _____ EMPLOYER_____
WORK: ☐ FULL TIME ☐PART TIME ☐ MORE THAN ONE JOB ☐RETIRED : YEAR_____ DISABLED : YEAR_____
MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED ☐SEPARATED PREGNANT? ☐YES ☐ NO

TOBACCO :	ALCOHOL	ILLICIT DRUGS	CAFFEINE_____
☐SMOKER : YRS SMOKED: _____	☐DRINK ALCOHOL	☐USE ILLICIT DRUGS	☐DRINK CAFFEINE
☐NON- SMOKER	PER DAY_____	☐DO NOT USE ILLICIT DRUGS	PER DAY_____
☐FORMER SMOKER	OR: PER WEEK_____	☐FORMER USER	OR: PER WEEK:_____
YRS SMOKED_____YEAR QUIT_____	OR: PER MONTH _____		OR: PER MONTH _____
	OR: NEVER _____		

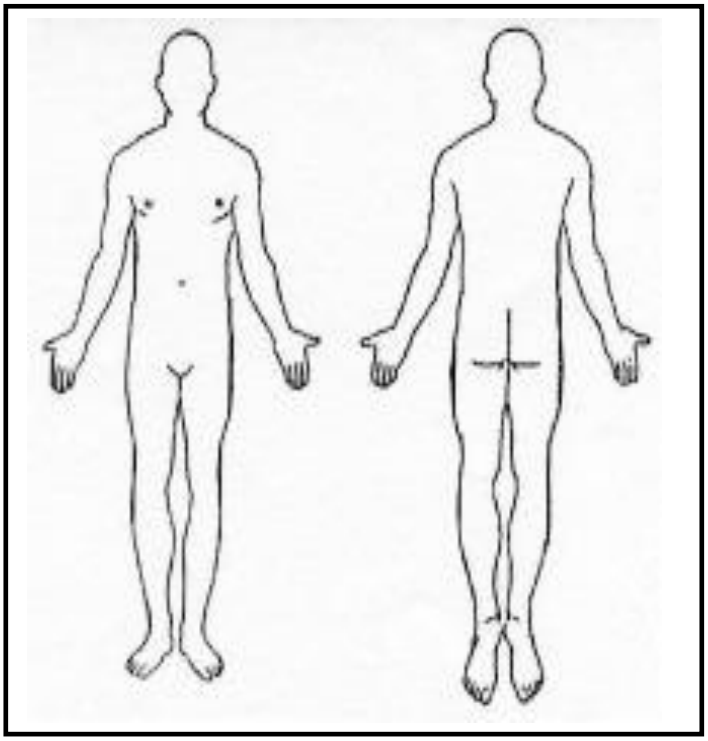
LIFESTYLE:
ACTIVITY LEVEL: ☐ SEDENTARY ☐ MODERATE ☐ VIGOROUS
EXERCISE FREQUENCY: ☐DAILY ☐1-2 TIMES PER WEEK ☐3-4 TIMES PER WEEK ☐ OCCASIONAL ☐NEVER

G): REVIEW OF SYSTEMS: HAVE YOU EVER HAD ANY PROBLEMS WITH THE FOLLOWING SYSTEMS: IF YES, EXPLAIN.

NOSE/THROAT	☐YES ☐NO	_____
EARS/HEARING	☐YES ☐NO	_____
RESPIRATORY	☐YES ☐NO	_____
CARDIOVASCULAR	☐YES ☐NO	_____
GASTROINTESTINAL	☐YES ☐NO	_____
GENITAL/URINARY/	☐YES ☐NO	_____
GYN	☐YES ☐NO	_____
SKIN	☐YES ☐NO	_____
NEUROLOGICAL	☐YES ☐NO	_____
OPTICAL/ EYE	☐YES ☐NO	_____
EMOTIONAL	☐YES ☐NO	_____
BLOOD DISORDERS	☐YES ☐NO	_____
GLANDS	☐YES ☐NO	_____
BONES/MUSCLES	☐YES ☐NO	_____

BODY PART INVOLVED: 1.) _____ ☐RIGHT ☐LEFT
2.)_____ ☐RIGHT ☐LEFT
3.)_____ ☐RIGHT ☐LEFT
4.)_____ ☐RIGHT ☐LEFT

PAIN DIAGRAM:
HOW LONG HAVE YOU BEEN EXPERIENCING PAIN? _____YEARS _____MONTHS _____WEEKS _____DAYS
ON THE DIAGRAM BELOW, PLEASE MARK WHERE YOU ARE CURRENTLY EXPERIENCING PAIN OR OTHER SYMPTOMS
A= ACHE B= BURNING N = NUMBNESS P= PINS & NEEDLES S= STABBING O= OTHER



WHAT IS YOUR CURRENT PAIN LEVEL ON A SCALE OF?
1 TO 10?
(WITH 1BEING: NO PAIN AND 10 BEING: EXCRUCIATING PAIN)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

QUALITY

☐DULL ☐SHARP ☐BURNING ☐ ACHING

OCCURRENCE

☐ CONSTANT ☐ INTERMITTENT ☐ RARE

MADE WORSE BY _____
_____
MADE BETTER BY: _____
_____

HAVE YOU HAD ANY PREVIOUS TREATMENT FOR THIS PAIN/PROBLEM? _____
_____
PHYSICAL THERAPY? WHEN? _____
_____
BRACING_____
INJECTIONS? _____
SURGERY?_____

ADDITIONAL INFORMATION FROM PREVIOUS SECTIONS:

LIST THE SECTION LETTER FIRST AND THEN THE ADDITIONAL INFORMATION:

_____
_____
_____
_____
_____
_____
_____

*This page reserved for internal physician and nurse use only

PATIENT NAME_____NEW PATIENT MEDICAL HISTORY (PAGE 4 OF 4)

PHYSICIAN NOTES:

Was this Hx form completed in its entirety? ☐YES ☐NO

Which section was missed or incomplete? _____

NOTES REGARDING PT HX: _____