Edward Diao, M.D.
Orthopaedic Surgery/Sports Medicine
Hand, Upper Extremity and Microvascular Surgery

New Worker's Compensation Intake Form ONLY

Patient's Name: Last Name First Name: Date of Birth Age

Home Address: # Street Apt # City State Zip

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

E-mail: Social Security # Gender M F

Marital Status □ Single □ Married □ Domestic Partner □ Divorced □ Widowed □ Spouse/Partner :

Ethnicity: Race: First Language:

Emer. Contact: Relationship: Phone ( )

Employment Information Are you currently working? □ Yes □ No Last worked date:

Employer: PHONE: FAX:

Referring MD:	**Primary MD:**
MD PHONE: MD FAX:	MD PHONE: MD FAX:
Worker's Compensation Insurance	**Claim Examiner's Information**
Date of Injury:	Adjustor's Name:
Workers Comp Carrier:	Adjustor's Address:
Claim Number:	Adjustor's Phone:
Mailing Address for Carrier:	Adjustor's Fax:
Nurse Case Manager :	**Attorney:**
Address:	Address:
Phone: Fax:	Phone: Fax:

Patient's Current Injury: Dominant Hand: □ Right □ Left **HEIGHT**: **WEIGHT**:

What **part of your body** is/was injured?

How did your **problem develop?** □ Over time □ It was an injury

Describe **HOW** the injury happened (briefly):

How do your symptoms limit your ability to perform **work duties**?

Do your symptoms affect your **activities of daily living**? If so, explain.

Do you have any **numbness and/or tingling**? If so, where?

Do your symptoms **keep you awake** at night? If so, explain.

Have you noticed any **weakness**? If so, explain.

Please describe any TREATMENT you have had for the present problem.

Patient Past Medical, Surgical, Medication and Allergies History:

List all **MEDICAL PROBLEMS & SURGERIES** you have had:

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List all of the current **MEDICATIONS / HERBAL TREATMENTS / SUPPLEMENTS** that you are taking. Including the **DOSAGES.** □ **None**

List all **ALLERGIES** you have (include name of medication and reaction): □ **No Known Allergies** □ **No Known Drug Allergies**

Patient Social History

What are your hobbies/interests?

Alcohol consumption: □ Never □ Rarely □ Socially □ Daily If so, how many drinks/week? _____

Cigarette use: □ Never □ Former □ Current #_____ per day, for _____ years If you have quit, how long ago? _____

Patient Health Review (Do you have any of the following? *If yes, please specify*)

GENERAL

Have you been in good general health most of your life? □ Yes □ No

Any allergies, including medication? □ Yes □ No

Any recent weight gain? □ Yes □ No

HEAD, EYES, NOSE, THROAT

□ Eye diseases or injury □ Wear glasses □ Double vision

□ Itchy eyes or nose □ Headaches □ Glaucoma

□ Ear Disease or impaired hearing

□ Runny nose, Nosebleeds, or chronic sinus trouble

□ Dizziness or transient episodes of unconsciousness?

LOCOMOTOR - MUSCULOSKELETAL

□ Varicose veins □ Weakness of muscle or joints

□ Difficulty walking □ Pain in calves or buttocks on walking, relives by rest?

RESPIRATORY

□ URI (cold) now □ Spitting up blood

□ Chronic of frequent cough □ Asthma or wheezing

□ Difficulty breathing

ENDOCRINE

□ Diabetes □ Thyroid Disease

□ Hormone Therapy □ Any changes in hat or glove size

NECK

□ Stiffness / Numbness □ Thyroid trouble

□ Enlarged Glands □ Swelling of hands, feet or ankles

SKIN

□ Skin disease □ Hives □ Eczema □ Frequent infections or boils

□ Jaundice □ Abnormal pigmentation □ Rash

GASTROINTESTINAL

□ Hepatitis □ Vomiting blood or food □ Gallbladder disease

□ Liver trouble □ Heartburn or indigestion □ Frequent Diarrhea

□ Black Stools □ Recent changes in bowel habits □ Hemorrhoids or piles

GENITOURINARY

□ Loss of urine or Frequent urination □ Night time urinating

□ Blood in urine □ Kidney trouble/ Stone

CARDIOVASCULAR

□ Shortness of breath with walking or lying down □ Heart murmur

□ Swelling of hands, feet or ankles □ High blood pressure

□ Chest pain or angina pectoris □ Heart trouble or heart attacks

NEURO - PSYCHIATRIC

□ Ever been advised to see a psychiatrist or had psychiatric care

□ Fainting spells □ Convulsions □ Paralysis

HEMATOLOGICAL

□ Blood disease □ Anemia □ Phlebitis

□ Slow to heal after cuts □ Bleeding excessively after tooth extraction or surgery

IMMUNE

□ Arthritis □ Have HIV/AIDS □ Any known hematologic condition

Family Health Review (Has any blood relative ever had any of the following?)

□ *M = Maternal / Mother,* □ *P = Paternal / Father*

Cancer	□ M	□ P	Suicide	□ M	□ P	Stroke	□ M	□ P	Tuberculosis	□ M	□ P
Diabetes	□ M	□ P	Heart Trouble	□ M	□ P	High Blood Pressure	□ M	□ P	Mental Illness	□ M	□ P
Convulsions	□ M	□ P	Bleeding Tendency	□ M	□ P	Gout □ Arthritis □	□ M	□ P	Hereditary Defects	□ M	□ P

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Consent to Treatment

I hereby request and consent to treatment for **myself** or my **child**, here at the office of Edward Diao, MD.

Authorization for Release of Medical Information

I authorize the release of any and all information acquired in the course of my examination and treatment of the purpose of securing payment of benefits for insurance company. A photocopy of this agreement is to be considered as valid as the original.

Assignment of Benefits

I hereby assign all surgical and/or medical benefits for services rendered; to be paid directly to the Office of Dr. Edward Diao will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Financial Policy

- Please be prepared to pay your co-payment at every visit. Your co-payment amount is usually indicated on your insurance I.D. card.
- Please be prepared to pay your deductible (if not met) and any co-insurance amount at the time of your visit.
- Please bring your current insurance I.D. card to every appointment. If you arrive for your appointment and we are unable to verify your insurance coverage or authorization, you may reschedule your appointment to a later date, or you may elect to keep your appointment that day, but will be required to pay for the visit. If you keep your appointment, we will make a reasonable attempt to bill your insurance and request a refund directly to you.
- If your insurance requires authorization from your primary care physician, please make sure that you have one that is valid for your visit and that it covers any necessary tests needed.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.
- We will do all we can to assist your with your health insurance claims, however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you.
- A returned check charge of $25 will be charged to my account for each returned check.
- I acknowledge there will be a charge of $50.00 for missed appointment or cancellation without 24 hours noticed.

Notice of Privacy Practice

Edward Diao, M.D. is committed to protecting the privacy of your medical and personal information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. Dr. Edward Diao, M.D. protects your personal and health information in electronic, written and oral forms when used throughout our organization. We may modify or change our privacy practices from time to time, particularly as new laws and regulations become effective. Any changes will be effective for all the personal and health information we maintain, even information in existence before the change. If we materially modify our privacy practices, we will provide you with a new notice advising you of the changes. So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

I have read and understand all the sections above.

Signature: _____ **Date:** _____

Out-of-Network Policy

I understand that Edward Diao, MD is not contracted with my insurance. I agree to make a partial payment or a deposit every visit. The fees are based on services provided on each visit, and can vary from visit to visit. This deposit will be based on a percentage of the total visit's fees. Dr. Diao's billing department will submit all charges to my insurance. My insurance company will render payment based on my health insurance policy. Once a determination is made by my insurance company, Dr. Diao's billing department will contact me to settle my account.

Signature: _____ **Date:** _____
(If applicable)

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CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medication (narcotics-opioids, tranquilizers, barbiturates, i.e. any drug which induces sleep or stupor) can be very useful, but have high potential for misuse or abuse and are, therefore, closely controlled by government agencies. Used properly, some of them can be very effective pain medicine. If used excessively, however, they can cause adverse effects, such as impaired judgment, vomiting, constipation, lethargy, organ damage, or even death. To ensure these medications are used properly, I agree to the following conditions.

1. I am RESPONSIBLE for my controlled substance medication. IF THE PRESCRIPTION OR MEDICATION IS LOST, STOLEN OR MISPLACED, OR IF I USE IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT WILL NOT BE REPLACED.

2. I will not request or accept narcotic medications from any other physician or individual while I am receiving such mediations from Edward Diao, MD (except if I am in the hospital). Besides being illegal to do so (NRS 453.39 1), it may endanger my health.

3. I understand that there will be a 24 to 48 hour turnaround time for non-narcotic medication refills; therefore, I will not wait until my medication is gone to request more medication. Controlled substances may be obtained only during a scheduled office visit. Refills will not be made at night, on holidays, or on weekends.

4. I understand that if I violate ANY of the above conditions my controlled substance medication may be discontinued immediately. I am aware of “narcotic effects”, including physiological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal may occur if I stop my medications abruptly) and the effects of addiction (psychological dependence), which is less common in patients with true pain. I also understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as an automobile. I must use special care while involved in activities requiring clear though and concentration.

_____ _____
Signature of Patient/Guardian Date signed

_____ _____
Witness Signature Date Signed

DISCLAIMER: Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Edward Diao will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.