

## Review of Systems

Do you now or have you recently had any problems related to the following systems? Circle YES or NO. If you mark yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Allergic/Immunological:

Hay Fever  Y  N  
Drug Allergies  Y  N  
Allergic seizure  Y  N  
Other: \_\_\_\_\_

### Cardiovascular:

Chest pain  Y  N  
Varicose veins  Y  N  
Leg swelling  Y  N  
Irregular Heartbeat  Y  N  
Other: \_\_\_\_\_

### Constitutional Symptoms:

Fever  Y  N  
Chills  Y  N  
Headache  Y  N  
Other: \_\_\_\_\_

### Ear/Nose/Throat/Mouth:

Ear Problems  Y  N  
Sore Throat  Y  N  
Sinus Problem  Y  N  
Other: \_\_\_\_\_

### Endocrine:

Excessive Thirst  Y  N  
Too hot/cold  Y  N  
Tired/Sluggish  Y  N  
Other: \_\_\_\_\_

### Eyes:

Blurred Vision  Y  N  
Double Vision  Y  N  
Pain  Y  N  
Other: \_\_\_\_\_

### Gastrointestinal:

Abdominal pain  Y  N  
Nausea/Vomiting  Y  N  
Indigestion/Heartburn  Y  N  
Other: \_\_\_\_\_

### Genitourinary:

Urine retention  Y  N  
Painful urination  Y  N  
Urinary frequency  Y  N  
Other: \_\_\_\_\_

### Hematological/Lymphatic:

Swollen glands  Y  N  
Blood clotting problem  Y  N  
Other: \_\_\_\_\_

### Integumentary:

Skin rash  Y  N  
Boils  Y  N  
Persistent itch  Y  N  
Other: \_\_\_\_\_

### Musculoskeletal:

Joint Pain  Y  N  
Neck Pain  Y  N  
Back Pain  Y  N  
Other: \_\_\_\_\_

### Neurological:

Seizures  Y  N  
Tremors  Y  N  
Dizzy Spells  Y  N  
Numbness/Tingling  Y  N  
Other: \_\_\_\_\_

### Psychological:

Do you suffer from depression?  Y  N  
Do you feel severely anxious or nervous?  Y  N  
Other: \_\_\_\_\_

### Respiratory:

Wheezing  Y  N  
Frequent cough  Y  N  
Shortness of breath  Y  N  
Other: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Medical History for \_\_\_\_\_ :

*We require that you specify whether or not you believe your medical problem IS or IS NOT related to a specific injury, so that your insurance claim for medical services rendered may be properly processed.*

### HISTORY OF PRESENTING ILLNESS:

My medical problem IS NOT related to an Injury

What area of the body is to be examined today? \_\_\_\_\_ (Be Specific – i.e. right knee)

When did your symptoms begin? \_\_\_\_\_

or

My medical problem IS related to an Injury

What area of the body is to be examined today? \_\_\_\_\_ (BE SPECIFIC)

When did your injury or onset of symptoms begin? Date of Injury: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please describe how this injury occurred: \_\_\_\_\_

Where did your injury occur?

Home

Work - if yes, Have you reported your condition to your employer?  YES  NO

MVA(Auto) if yes, Have you reported the accident and injury to your Auto Insurance Company?

Other: \_\_\_\_\_ (Please be specific)

IF yes, Did your injury occur somewhere other than your own property?  YES  NO

Is your injury related to a work or a motor vehicle accident?  YES  NO

**\*\*Could this injury/medical problem be related to a pre-existing condition with your insurance company?  YES  NO**

**Occupation:** \_\_\_\_\_  Full-Time  Part-Time  Student  Retired

• Are you currently working?  YES  NO-Last day: \_\_\_\_\_  Unemployed  Disabled

○ Reason not working: \_\_\_\_\_

### HEALTH HISTORY:

• Hand Dominance:  RIGHT  LEFT  AMBIDEXTROUS

• Height \_\_\_\_\_ Weight \_\_\_\_\_ Age: Age Date of Birth: Date of Birth

• Do you smoke?  YES  NO How Much? \_\_\_\_\_ Per Day For How Long? \_\_\_\_\_

• Have you quit?  YES  NO When? \_\_\_\_\_

• Do you Drink Alcohol?  YES  NO

• How much?  Socially  Weekly  Daily  Monthly  Rarely

• Is there any chance you could be pregnant?  YES  NO

• Date of Last Menstrual Period: \_\_\_\_\_

• Have you been tested for HIV/AIDS?  YES  NO

• Do you

Please list **ALL Medications** with Dosages (Prescription, Vitamins, Herbal, Medical Marijuana & etc.):  NONE

Please list **ALL Allergies** to any Medications, Latex, Tapes, Etc.:  NONE

Please list **ALL previous orthopedic conditions &/or fractures** you've had & the year:  NONE

Please list **ALL types of Surgeries** you have had & the Year- *Including which body area*  NONE

**Please Circle "Y" or "N" for any medical conditions YOU suffer from:**

Anemia	Y	N	Emphysema	Y	N	Heart Problems	Y	N	Polio	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Fibromyalgia	Y	N	Hiatal Hernia	Y	N	Scoliosis	Y	N
Bladder/Prostate Problems	Y	N	Frequent Headache/Migraine	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Blood Clots	Y	N	Gall Bladder	Y	N	Kidney Disorder	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Head Injury	Y	N	Liver Disease/Jaundice	Y	N	Thyroid Disorder	Y	N
Cancer	Y	N	Hearing Problems	Y	N	Meningitis	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Heart Attack	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N
Sleep Apnea (use of CPAP)	Y	N	Heart Catheterizations	Y	N	Pneumonia	Y	N	Weakness or Paralysis	Y	N

### Family History –

**Please Circle "Y" or "N" for any conditions YOUR FAMILY suffers from:**

Anemia	Y	N	Emphysema	Y	N	Heart Problems	Y	N	Polio	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Fibromyalgia	Y	N	Hiatal Hernia	Y	N	Scoliosis	Y	N
Bladder/Prostate Problems	Y	N	Frequent Headache/Migraine	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Blood Clots	Y	N	Gall Bladder	Y	N	Kidney Disorder	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Head Injury	Y	N	Liver Disease/Jaundice	Y	N	Thyroid Disorder	Y	N
Cancer	Y	N	Hearing Problems	Y	N	Meningitis	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Heart Attack	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N
	Y	N	Heart Catheterizations	Y	N	Pneumonia	Y	N	Weakness or Paralysis	Y	N

*The above information is completed to the best of my knowledge*

(History for: \_\_\_\_\_)

**Patient Signature**

**Date**



E. Patrick Mitchell, DO \* Philip T. Schmitt, DO \*  
Roland J. Brandt, DO \* Steven M. Zavinsky, DPM \* Michael S. Smith PA-C

The Sinai Guild Medical Office Building  
1 William Carls Drive, Suite 120  
Commerce Township Michigan, 48382  
248-937-4947(voice) 248-937-5150 (fax)

**Registration Form**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

*\*\*Please add Middle Initial above - Thanks*

Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_  Full Time  Part Time  Student  
 Retired  Unemployed  Disabled

Emergency Contact Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

***(Please do NOT use your Home Phone number for the Emergency Contact!!!)***

Family Physician/Internist: \_\_\_\_\_ Phone#: \_\_\_\_\_

Did your Family Physician/Internist refer you to us? YES NO  
If NO, please list referring Physician \_\_\_\_\_

Did someone other than a physician refer you? YES NO Who? \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy # \_\_\_\_\_

**Responsible Party Information (If other than Patient)**

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE: Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
SSN: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_ Retired? YES NO

SECONDARY INSURANCE: Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
SSN: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_ Retired? YES NO

Do you believe your condition is *WORK* related?  YES  NO  ?  
Have you reported your condition to your employer?  YES  NO  N/A  
Is there an active claim for this condition?  YES  NO  
Is your injury the result of an *AUTO* related injury?  YES  NO  
Have you reported the accident and injury to your Auto Insurance Company?  YES  NO  
Auto Insurance Company: \_\_\_\_\_  
Claim number: \_\_\_\_\_ Adjuster Phone number: \_\_\_\_\_

Could this injury result in a *LIABILITY*?  YES  NO  
Injury Location: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

***\*\* You MUST provide us with the insurance information at the time of your appointment for any WORK, AUTO, and/or LIABILITY injury in order to be seen. According to insurance guidelines, which we MUST follow, we may NOT bill health insurance for these types of injuries, unless a special coordination of benefits exists with your health insurance.\*\****

I AUTHORIZE SPECIALISTS IN ORTHOPEDIC SURGERY TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO SPECIALISTS IN ORTHOPEDIC SURGERY FOR SERVICES RENDERED. I AGREE TO PAY MY COPAYS, DEDUCTIBLES, AND ANY BALANCE THAT IS DENIED OR IN DISPUTE BY MY INSURANCE COMPANY.

**SIGNATURE** \_\_\_\_\_  
(PATIENT, PARENT, OR RESPONSIBLE PARTY)

DATE:

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Acknowledgement of Receipt  
of  
Notice of Privacy Practices

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
**Signature**

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**“GOOD FAITH REPORT”**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

The patient presented for treatment on this date and was provided with a copy of the practice’s Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained because:

Patient refused to sign

Patient was unable to sign because: \_\_\_\_\_

There was a medical emergency and the practice will attempt to obtain acknowledgement at the next available opportunity.

Other: \_\_\_\_\_

Signature of employee completing this form: \_\_\_\_\_



E. Patrick Mitchell, DO \* Philip T. Schmitt, DO \*  
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Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, \_\_\_\_\_ authorize Specialists in Orthopedic Surgery, PLLC to release and obtain my private health information to whom may require it for my care.

Please do **NOT** disclose any protected health information to the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

May our office leave a message on your machine?       Yes       No

Are there any restrictions on PHI to be disclosed       Yes       No

If yes:  
\_\_\_\_\_  
\_\_\_\_\_

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with Specialists in Orthopedic Surgery, PLLC. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention *Privacy Officer at, The Sinai Guild Medical Office Building ste 120, 1 William Carls Drive, Commerce, MI 48382*. I understand that my revocation will not affect any actions taken by Specialists in Orthopedic Surgery, PLLC prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed. At which time this authorization to obtain and release this protected health information expires.

\_\_\_\_\_  
Patient Signature or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name Printed

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# DISABILITY / MEDICAL FORMS

Practice Policy for forms including disability, life, supplemental insurance, extension of disability, or any form pertaining to time off work is as follows:

1. All forms must be turned into front desk receptionist at time of check in.
2. There is a \$10.00 charge for each form to be filled out.
3. Due to HIPAA regulations we are unable to fax any form unless the proper paperwork has been filled out by the requesting company. All forms must be either mailed to the company, the patient, or be picked up in the office by the patient or an authorized representative.
4. There will be up to a 7 – 10 business day processing period for all forms. This allows time for preparing the form, receiving approval and obtaining a signature from the physician.

I have read and understand the above information regarding  
disability/medical forms.

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**Patient Signature**

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Date

Patient Name: \_\_\_\_\_

## INSURANCE AUTHORIZATION

Patients must sign this form in order to bill their health insurance for the charges incurred either inpatient, outpatient or for office procedures.

I, \_\_\_\_\_ request payment of authorized benefits of my health insurance to be made to Specialists in Orthopedic Surgery for any services furnished to me by them. I authorize any holder of medical information about me to release to Health Care Financing Administration and agents.

This form enables Specialists in Orthopedic Surgery to bill services on our online terminal to my health insurance directly.

\_\_\_\_\_  
Patient Signature or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient if not self