

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? Right/Left _____

On what date did your symptoms begin? _____

or

My medical problem IS related to an Injury

What area of the body is to be examined today? Right/Left _____

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 _____

• 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: _____

Marital Status:

• Married Widow Divorced Single Significant other Separated

• Is there someone in the household to assist you if necessary? Yes No

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	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
HIV/Aids	Y	N	Prostate Problems	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: _____

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

“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: _____

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.**

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

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