CHECK LIST FOR APPOINTMENT:

As a new patient to our practice, we would like to welcome you and provide you with important information. Please review the items needed for your appointment to ensure that your experience is efficient and satisfactory.

Your appointment date:________________________time:_________________________

Doctor:___________________________________Location:____

Print off and complete the patient forms associated with the physician you will be seeing. If you are reading this notice, you are here (please print the entire packet). If you have completed this packet, please bring with you and arrive 10-15 min prior to your first appointment. **If you do not have a computer with printing abilities then you MUST arrive to the office 45 minutes early to fill out all necessary paperwork.**

In addition to the New Patient Packet you must also bring the following:

- ✓ Picture ID (drivers license or state ID)
- ✓ Insurance Cards. If you have an HMO, you MUST bring a referral with you if required (most office will no longer fax referrals). You will NOT be seen without a referral.
- ✓ Your Copay and Deductible (if applicable). Our financial policy is located on our website under the "Patient Forms" tab.
- ✓ Work-Related or Auto-Related injuries require a written letter of open claim. This letter must include the claim #, billing address, name and phone number of contact person (case manager).
- ✓ If you have underwent diagnostic testing (ie., Xrays, MRI, CT, EMG, etc.) prior to your appointment then you must bring the actual images to your appointment. Radiology Reports alone are not acceptable. Please bring the images via hard films/hard copy or CD of images.
- ✓ List of medications, supplements, allergies.
- ✓ Primary Care Doctor, Referring Doctor, and Cardiologist (if applicable) address, and phone numbers. This will allow us to coordinate care if appropriate.
- ✓ Pharmacy name, address, and phone number.
- ✓ Email Address, so that you can register for an access your electronic medical record.
- ✓ If there is a language barrier, you will need to bring a translator that is 18 years of age or older that reads, writes and understands the English Language.
- ✓ If you are a minor, you will need to have an adult/guardian with you at all times.

Due to the nature and complexity of some orthopedic conditions, an extended amount of time (2-3 hours) should be allotted for your initial evaluation. Please plan accordingly. We also advise that you read the attached sheets which include basic policies of our office. You will be asked to sign these forms. If there any are any questions they can be addressed at the office.

Driving directions to all of our office are noted on the Locations Tab of our website www.miortho.com

We look forward to providing care for you!

PATIENT INFORMATION (PLEASE PRINT)

APPT DATE:____________________

Last Name, First Name, Middle:____

Street Address, City, State, Zip :____

Cell Phone:________________________________ **Home Phone:**____

Social Security No:_______________ **DOB:**_________________ **Age:**_________ **Sex:** [ ] Male [ ]Female

Email:____ **Occupation:**_______________________________________

Emergency Contact:__________________________ **Relationship**___________________ **Phone:**_______________________

If Minor: Parent/Legal Guardian Name :______________________________________ ***Cell#*** _______________________

Work Status: [ ] Full time [ ] Part time [ ] Homemaker [ ]Disabled [ ] Retired [ ]Unemployed [ ] Other:_____________

Where do you live: [ ]Home [ ]Other:___________________________

Marital Status: [ ] Single [ ]Married [ ] Widowed **[ ]Divorced** **Language:** [ ]English [ ]Spanish [ ]Declined

Ethnicity: [ ]Decline [ ]Hispanic /Latino [ ]Other:______________

Race: [ ]Declined [ ]Caucasian [ ] Black [ ] Asian [ ] Native American

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How did you hear about us? [ ]Physician [ ]Internet [ ]Friend/Family [ ]Hospital/ED [ ]Other:__________________

Referring Physician:_________________________________ City: ____________________Phone:_______________________

Primary Care Physician: ______________________________City: ____________________Phone:_______________________

Cardiology Physician: ________________________________City: ____________________Phone:_______________________

Name of Primary Insurance:____________________________________ **Employer:**______________________________

Subscriber Name:_______________________________ **Subscriber SS No:**_________________________________

Subscriber DOB:____________________ **Group #:**______________________ **Policy #:**____________________________

Patient Relationship to the subscriber: [ ]**Self** [ ]**Spouse** [ ] **Child** [ ]**Other:**______________________________

Name of Secondary Insurance:_________________________________ **Employer:**____________________________

Subscriber Name: ____________________________________ **Subscriber SS No:**____________________________

Subscriber DOB: __________________ **Group #:**_________________________ **Policy #:**_____________________________

Patient Relationship to the subscriber: [ ]**Self** [ ]**Spouse** [ ]**Child** [ ] **Other:**______________________________

Last Name, First Name, Middle:____ DOB:____________

Auto/Workers Comp/Other Carrier

DO YOU HAVE AN INJURY? [ ]YES [ ]NO DATE OF INJURY:_____/______/_______

Do you have an open claim? MUST COMPLETE BELOW

Auto: [ ]Yes [ ]No Workers Comp: [ ]Yes [ ]No Other Liability: [ ]Yes [ ]No

Claim #:__________________________ Treated in the Emergency Room? [ ] Yes [ ]No Which One:_____________________

Body Part Injured:______________________________ If Applicable: [ ] Right or [ ] Left

Current Work Restrictions: [ ] Regular [ ] Light Duty [ ] Not working due to Injury [ ] Disabled

Are you currently receiving or do you plan to apply for: **[ ] Disability [ ]Workers Comp [ ] Unemployment**

Last Date worked at your regular job? _______________________

Insured Name:____

Last Name, First Name, Middle

Do you have coordination of benefits: **[ ]** Yes **[ ]**No **Is your regular health insurance primary**: **[ ]**Yes **[ ]**No

Carrier Name	Address:	Phone:
Adjuster Name:	Email:	Phone:
Case Manager Name:	Email:	Phone:

AUTHORIZATION FOR TREATMENT &PAYMENT

The above information is true to the best of my knowledge. I hereby authorize treatment of the above named person and acknowledge to that I am able to read, write and understand English and if not, I have brought an adult with me who is able to interpret on my behalf. I authorize my doctor's billing pc, Michigan Orthopedic Specialists and it's agents to furnish information to my current or future insurance carrier(s) any information needed for the purposes of securing payment for services provided and assign all payment for services provided to the treating physician. I u n d e r s t a n d that I am financially responsible for any amounts not covered by my insurance and any co-pay, co-insurance, balance or deductible will be collected before I am treated by the physician. Any amounts owing after my insurance has paid their portion will be remitted p r o m p t l y upon receipt of a statement. It is my responsibility to obtain any authorization required prior to seeing the specialist and I may not be seen without it if required due to insurance.

PATIENT/GUARDIAN SIGNATURE: __________________________________ DATE: ________________

ACKOWLEDGEMENT OF FINANCIAL POLICY

By signing below I acknowledge that I have reviewed a copy of this office's Financial Policy which is available at the office or on the website www.miortho.com.

PATIENT/GUARDIAN SIGNATURE:__________________________________ DATE:__________________

Patient Name:_____________________________________**DOB:**__________________________

Pharmacy: _____________________ **City:** __________________**Phone:**_____________________

Allergies	Reactions

Medications	Dosage

For additional Medications please provide list

DR. RAMAKRISHNAN'S PAIN MEDICATION POLICY

No prescription Narcotics will be dispensed until after you have been evaluated, deemed a surgical candidate, and surgery has been scheduled. All medication refills must be called in to the refill line within 72 hours of running out.

If you have had surgery by Dr. Ramakrishnan, pain medication will be prescribed for a maximum of 2 months after surgery. Your primary care physician is responsible for any pain management after that point. All prescriptions will be for a 7 day supply or less.

When receiving pain medications by Dr. Ramakrishnan, you must disclose any other sources from which you are receiving pain medications. Random pharmacy database checks will be made, and if you are receiving pain medications from multiple doctors, your pain medication will be terminated.

Your medication is your responsibility; if lost or stolen, it will not be refilled until the appropriate date.

DR. RAMAKRISHNAN'S DISABILITY POLICY

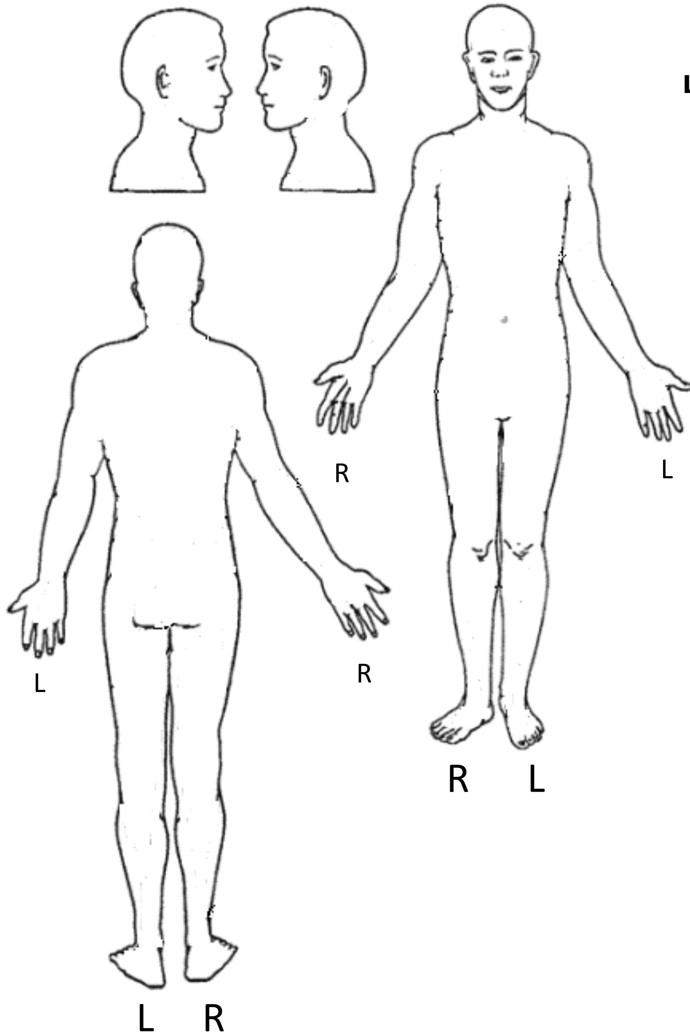
No work notes will be filled out unless you have been evaluated, deemed a surgical candidate, and surgery has been scheduled. NO PERMANENT DISABILITY WILL BE GIVEN TO ANY PATIENT.

Patient Signature:_____________________________________ **Date:**_______________________

Name:________________________ DOB:________ Age:______ Sex:______ Appt Date: ____/____/_____

Cell/Home Phone Number: _________________ Other contact number: _____________________________

Height: _________ Weight: _________ PCP:_________________ Referred by:____________________



For the appropriate body part
Please circle the number that corresponds to your **average** pain over the last few days.

Neck	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible
Arms	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible
Back	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible
Leg/Buttocks	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible

1. **How long have you had this issue for?**
   Neck ______________ Back______________
2. **Was there a specific injury?**__________________________
3. **Were your current problems related to a work/Auto injury?**

   ☐ Work ☐ motor vehicle accident? ☐ NO
   (if work or motor vehicle accident selected complete the next two questions)

   - **What Happened and Date**__________________________
     ____
     ____
     ____
   - **Any issues prior to injury:** Yes No
     ____
     ____
4. **Have you had any BOWEL OR BLADDER incontinence**? YES NO
   Which one?____
5. **Do you have balance problems with walking?** YES NO
6. **Do you have problems w/ fine motor skills in your hands**:
   Yes No
7. **Missed work because of this problem?** YES No
8. **What makes it feel**
   - Better**:**_____________________________________
   - Worse**:** _____________________________________
9. **How long can you stand**: ________ **Walk**: __________
10. **What can't you do due to this problem: (cleaning, groceries etc)**
    ____
    ____
    ____

Name:_____________________________ DOB:______________________

Please Check below what kind of TREATMENT/ WORKUP you have had for this issue.

	Yes			Does it help?
Medications for Pain:	☐	**What Kind?**	**For how long?**	
Physical Therapy ☐ Neck ☐ Back	☐	**How many weeks?**	**Where?**	
Chiropractor ☐ Neck ☐ Back	☐	**How Long?**	**Where?**	
Pain Clinic? Injections? **DR.___________________** ☐ Neck ☐ Back	☐	**Type of injections:** **# of Injections:** **Last injection:**		
MRI ☐ Neck ☐ Back	☐	**When:**	**Where?**	
CT SCAN ☐ Neck ☐ Back	☐	**When:**	**Where?**	
EMG	☐	**When:**	**Where?**	
OTHER STUDIES	☐			

Have you had any Spine Surgeries: ☐ YES (if yes please list below) ☐ NO

When	Where	Surgeon	Type