

CHECK LIST FOR APPOINTMENT: **\*\*\* DUE TO COVID PANDEMIC – WEAR MASK/NO VISITORS AT THIS TIME\*\*\***

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, there could be a wait. Please know that we give each patient the same personalized attention. Your patience is appreciated.** 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 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](http://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

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:
Attorney	Email:	Phone:

**PLEASE REFER TO THE FINANCIAL POLICY WHICH IS AVAILABLE AT THE FRONT DESK OR ON OUR WEBSITE FOR IMPORTANT INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITIES PERTAINING TO THIS CLAIM FOR SERVICES. IT IS YOUR RESPONSIBILITY TO KEEP THE OFFICE INFORMED OF ANY CHANGES IN YOUR CLAIM.**

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

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

DOB: \_\_\_\_\_

**Medical Disorders: Please Place Mark Inside Circles:**

- |  |  |   |
|--|--|---|
| <input type="radio"/> No Medical History         | <input type="radio"/> Stroke   | <input type="radio"/> Sleep Apnea         |
| <input type="radio"/> AIDS/HIV                   | <input type="radio"/> Cancer Breast                                    | <input type="radio"/> Gout                |
| <input type="radio"/> Alcoholism                 | <input type="radio"/> Cancer Colon                                     | <input type="radio"/> Heart Attack        |
| <input type="radio"/> Alzheimer's                | <input type="radio"/> Cancer Lung                                      | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Anemia                     | <input type="radio"/> Cancer Prostate                                  | <input type="radio"/> Hepatitis           |
| <input type="radio"/> Rheumatoid Arthritis       | <input type="radio"/> COPD   | <input type="radio"/> Kidney Disease      |
| <input type="radio"/> Asthma                     | <input type="radio"/> Depression                                       | <input type="radio"/> Osteoarthritis      |
| <input type="radio"/> Blood Clot Leg             | <input type="radio"/> Diabetes   | <input type="radio"/> Seizures            |
| <input type="radio"/> Blood Clot Lung            | <input type="radio"/> Drug Abuse                                       | <input type="radio"/> Ulcers, Bleeding    |
| <input type="radio"/> Other Disease (list below) | <input type="radio"/> Blood thinners (Coumadin, Plavix, aspirin, etc.) |   |

**Surgical History: Please Place Mark Inside Circles:**

- |  |  |
|--|--|
| <input type="radio"/> No Surgical History Reported | <input type="radio"/> Cardiac (Heart)            |
| <input type="radio"/> Carpal Tunnel Left Wrist     | <input type="radio"/> Carpal Tunnel Right Wrist  |
| <input type="radio"/> Arthroscopy Left Elbow       | <input type="radio"/> Arthroscopy Right Elbow    |
| <input type="radio"/> Arthroscopy Left Shoulder    | <input type="radio"/> Arthroscopy Right Shoulder |
| <input type="radio"/> Arthroscopy Left Ankle       | <input type="radio"/> Arthroscopy Right Ankle    |
| <input type="radio"/> Arthroscopy Left Knee        | <input type="radio"/> Arthroscopy Right Knee     |
| <input type="radio"/> Arthroscopy Left Hip         | <input type="radio"/> Arthroscopy Right Hip      |
| <input type="radio"/> Left Hip Replacement         | <input type="radio"/> Right Hip Replacement      |
| <input type="radio"/> Left Knee Replacement        | <input type="radio"/> Right Knee Replacement     |
| <input type="radio"/> Spinal Fusion                | <input type="radio"/> Laminectomy                |
| <input type="radio"/> Other Surgery (list below)   | <input type="radio"/> Fracture Surgery           |

**Family History: If any family member has the following history, Please Place Mark Inside Circles:**

- |  |                              |                              |                               |
|--|------------------------------|------------------------------|-------------------------------|
| <input type="radio"/> AIDS/HIV             | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Anemia               | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Blood Clots          | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Cancer               | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Diabetes             | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Gout                 | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Heart Attack         | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Hemophilia           | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Hypertension         | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Kidney Disease       | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Liver Disease        | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Muscle Disease       | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Osteoporosis         | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |
| <input type="radio"/> Osteoarthritis       | <input type="radio"/> Father | <input type="radio"/> Mother | <input type="radio"/> Sibling |

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Review of Systems: If you have any of the following, Please Place Mark Inside Circles:**

**Constitutional**

- Weight Loss/Gain
- Weakness
- Fatigue
- Fever

**Cardiovascular**

- High Blood Pressure
- Chest Pain
- Rheumatic Fever
- Palpitations
- Has Pacemaker

**Musculoskeletal**

- Joint Pain
- Arthritis
- Muscular Weakness
- Stiffness
- Muscular Pain

**Eyes**

- Glasses or Contacts
- Blurred Vision
- Glaucoma
- Cataracts
- Excessive Tearing

**Skin**

- Rashes
- Sores
- Lumps
- Dryness
- Itching

**Blood or Lymph**

- Anemia
- Easy Bruising
- Easy Bleeding
- Swollen Glands

**Ear Nose Mouth Throat**

- Ears Ringing
- Earaches
- Hearing Aid
- Frequent Colds
- Nasal Discharge
- Hay Fever
- Nose Bleeds
- Bleeding Gums
- Frequent Sore throats

**Neurological**

- Headache
- Dizziness
- Seizures
- Loss of Sensation
- Vertigo

**Respiratory**

- Shortness of Breath
- Cough
- Wheezing
- Asthma
- Bronchitis

**Gastrointestinal**

- Heart Burn
- Rectal Bleeding
- Abdominal Pain
- Gallbladder Trouble
- Hepatitis

**Genitourinary**

- Blood in Urine
- Urinary Infections
- Kidney Stones
- Burning Urination
- Sexual Disease

**Endocrine**

- Thyroid Trouble
- Excessive Sweating
- Excessive Thirst

**Immunologic**

- Reactions to Drugs
- Skin Rashes
- Reactions to Food

**Psychological**

- Nervousness
- Depression
- Mood Changes

**Social History: Please respond to the following by Placing Mark Inside Circles:**

**Substance Use:**

**Do you:**

- |                    |                           |                          |                              |
|--------------------|---------------------------|--------------------------|------------------------------|
| Use Tobacco?       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Former |
| Use Alcohol?       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Former |
| Use Caffeine?      | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Former |
| Use illicit Drugs? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> former |

**Hand Dominance:**

- |                                       |                                      |
|---------------------------------------|--------------------------------------|
| <input type="radio"/> Right<br>Handed | <input type="radio"/> Left<br>Handed |
|---------------------------------------|--------------------------------------|

**Females Only:**

- Could you be Pregnant?
- |                           |                          |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|--------------------------|

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

What body part is involved? \_\_\_\_\_  right  left

What is the main reason for this visit?  pain  numbness  weakness  swelling  stiffness

other \_\_\_\_\_ When did it start? \_\_\_\_\_ (date)

If Injury, please explain \_\_\_\_\_

Have you had a problem like this before?  yes  no If yes, when: \_\_\_\_\_

On a scale of 1-10 (10 is the worst), How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10 (circle)

What is the quality of the pain?  sharp  dull  stabbing  throbbing  aching  burning

The pain is:  constant  comes and goes Does your pain wake you from sleep?  yes  no

Do you have  swelling  bruising  numbness  tingling  weakness  loss of bowel/bladder

Since my problem started, it is  getting better  getting worse  unchanged

What makes your symptoms worse?  standing  walking  squatting  exercising  twisting

sitting  stairs  lifting  kneeling  bending  coughing  sneezing  lying in bed

What makes your symptoms **better**?  rest  elevation  ice  heat  other \_\_\_\_\_

Have you had any of these treatments? Injection:  yes  no brace:  yes  no

physical therapy:  yes  no cane/crutch:  yes  no

What tests have you had for this problem?  x-rays  MRI  CT scan  bone scan  EMG Have

you had surgery for a problem in the same area either recently or in the past?  yes  no

If yes, previous surgery and date: \_\_\_\_\_

Current work status:  regular  light duty (how long? \_\_\_\_\_)  not working due to this problem

disabled  retired  student

When is the last date you worked your regular job? \_\_\_\_\_

Are you currently receiving or do you plan to apply for: disability  yes  no

workers' comp  yes  no unemployment  yes  no

**MEDICATION RECORD**

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

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**ALLERGIES/REACTIONS**

<b><u>Allergic To:</u></b>	<b><u>Reaction:</u></b>

**CURRENT MEDICATION**  
**PLEASE INCLUDE SUPPLEMENTS AND VITAMINS**

<b>DATE</b>	<b>MEDICATION</b>	<b>DOSAGE</b>	<b>QTY</b>

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

PATIENTNAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**PAIN MEDICATION POLICY**

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

If you have had surgery by the doctor, 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 the doctor 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.

**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.

**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 and Michigan Orthopedic Specialists and its 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.

**ACKNOWLEDGEMENT 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](http://www.miortho.com).

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

STAFF WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_