

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

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
Handed | <input type="radio"/> Left
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

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

CURRENT MEDICATION
PLEASE INCLUDE SUPPLEMENTS AND VITAMINS

DATE	MEDICATION	DOSAGE	QTY

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.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

STAFF WITNESS: _____ DATE: _____