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, 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:
Attorney	Email:	Phone:

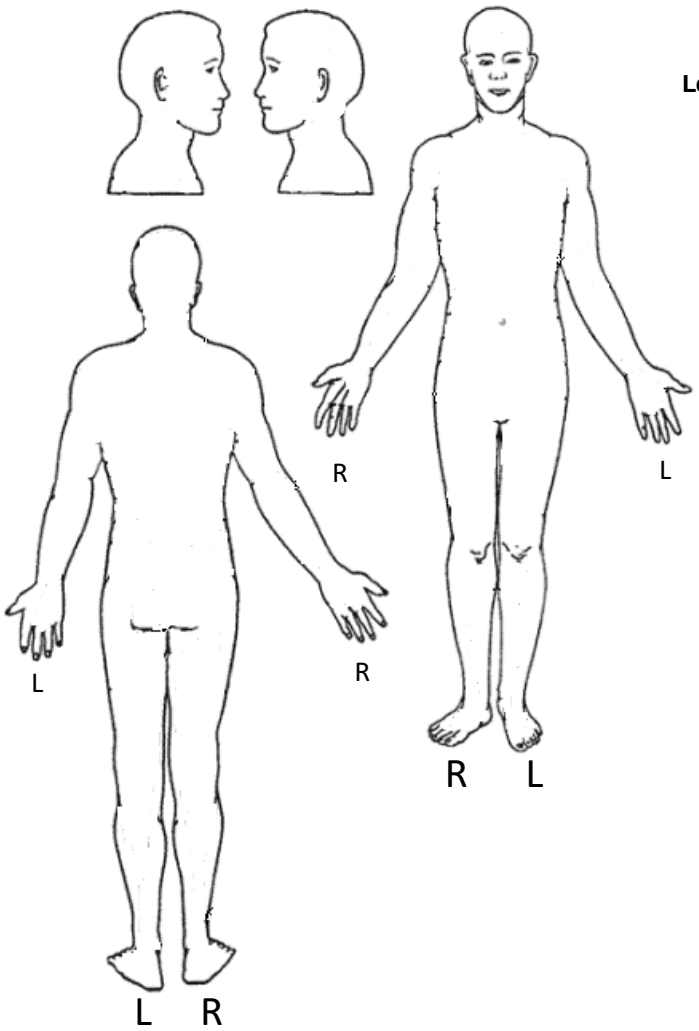
PLEASE REFER TO THE FINANCIAL POLICY WHICH IS AVAILABLE AT THE FRONT DESK OR ON OUR WEBSITE FOR IMPORTANT INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITIES PERTAINING TO THIS CLAIM FOR SERVICES. IT IS YOUR RESPONSIBILITY TO KEEP THE OFFICE INFORMED OF ANY CHANGES IN YOUR CLAIM.

Name:_____**DOB**:_____**Age**:_____ **Sex:**_____ **Appt Date**:____/____/_____

Cell/Home Phone Number:_____**Other contact number:** _____

Height: _____ **Weight**: _____ **PCP:**_____ **Referred by**:_____

>> Numbness
000 Pins and Needles
XXX Burning
●●● Aching/Pain



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

Patient Last Name: _____ First Name: _____ DOB:_____

Medical Disorders: Please Place Mark Inside Circles:

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

Surgical History: Please Place Mark Inside Circles:

- O No Surgical History Reported
- O Carpal Tunnel Left Wrist
- O Arthroscopy Left Elbow
- O Arthroscopy Left Shoulder
- O Arthroscopy Left Ankle
- O Arthroscopy Left Knee
- O Arthroscopy Left Hip
- O Left Hip Replacement
- O Left Knee Replacement
- O Spinal Fusion
- O Other Surgery (list below)
- O Cardiac (Heart)
- O Carpal Tunnel Right Wrist
- O Arthroscopy Right Elbow
- O Arthroscopy Right Shoulder
- O Arthroscopy Right Ankle
- O Arthroscopy Right Knee
- O Arthroscopy Right Hip
- O Right Hip Replacement
- O Right Knee Replacement
- O Laminectomy
- O Fracture Surgery

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

O AIDS/HIV	O Father	O Mother	O Sibling
O Anemia	O Father	O Mother	O Sibling
O Blood Clots	O Father	O Mother	O Sibling
O Cancer	O Father	O Mother	O Sibling
O Diabetes	O Father	O Mother	O Sibling
O Gout	O Father	O Mother	O Sibling
O Heart Attack	O Father	O Mother	O Sibling
O Hemophilia	O Father	O Mother	O Sibling
O Hypertension	O Father	O Mother	O Sibling
O Kidney Disease	O Father	O Mother	O Sibling
O Liver Disease	O Father	O Mother	O Sibling
O Muscle Disease	O Father	O Mother	O Sibling
O Osteoporosis	O Father	O Mother	O Sibling
O Rheumatoid Arthritis	O Father	O Mother	O Sibling
O Osteoarthritis	O Father	O Mother	O Sibling

Patient Last Name: _____ First Name: _____ DOB: _____

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

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O Hugh Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

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

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

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

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

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

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

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

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive Thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Food

Psychological
- O Nervousness
- O Depression
- O Mood Changes

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

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	O Former
Use Caffeine?	O Yes	O No	O Former
Use illicit Drugs?	O Yes	O No	O former

Hand Dominance: O Right Handed O Left Handed

Females Only:

Could you be Pregnant? O Yes O No

MEDICATION RECORD – Dr. Rakesh Ramakrishnan

Patient Name:_____ **DOB:**_____

Pharmacy:_____ **Phone:**_____ **Fax:**_____

Address:_____

ALLERGIES/REACTIONS

Allergic To:	Reaction:

CURRENT MEDICATION
PLEASE INCLUDE SUPPLEMENTS AND VITAMINS

DATE	MEDICATION	DOSAGE	QTY

Patient Signature:_____ **Date**_____

PATIENTNAME:_____ **DOB:**_____

DR. RAMAKRISHNAN'S PAIN MEDICATION POLICY

No prescription Narcotics will be dispensed unless you have been evaluated, deemed a surgical candidate, and surgery has been scheduled.

Refills must be called in to the refill line within 48 hours of running out.

If you have had surgery by Dr. Ramakrishnan, pain medication will be prescribed for 3 months after surgery. Your primary care physician is responsible for any pain management after that point.

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.

DR. RAMAKRISHNAN'S INSTRUCTIONS FOLLOWING AN MRI OR CT SCAN

After your MRI or CT scan has been completed, you will be given a disc or film. If the technician does not give this to you – **you must request and bring the disc or film to your follow-up visit**. The disc or film **MUST** be presented to Dr. Patel at **EVERY** visit for follow up care. This information is necessary in order for us to provide the best care possible and your follow up visit may not be completed without it.

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 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.

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/GUARDIANSIGNATURE:_____ **DATE:**_____

STAFFWITNESS:_____ **DATE:**_____