DEARBORN ORTHOPEDICS & SPORTS MEDICINE, P.C.

PATIENT DEMOGRAPHICS FORM

PATIENT NAME:

_____

FIRST M.I. LAST

DATE OF BIRTH: _____ **AGE:** _____ **SSN# (LAST FOUR ONLY)** _____

IF MINOR, NAME OF PARENT(S)/LEGAL GUARDIAN(S):

_____

SEX: MALE OR FEMALE (CIRCLE) **MARITAL STATUS:** SINGLE MARRIED DIVORCE WIDOWED (CIRCLE)

ADDRESS:

_____

STREET CITY STATE ZIP CODE

HOME OR CELL PHONE #: _____ **OK TO LEAVE A MESSAGE?** YES OR NO (CIRCLE)

PATIENT'S EMERGENCY CONTACT: _____ **PHONE #** _____

PATIENT'S EMPLOYER NAME: _____ **OCCUPATION:** _____

IS THIS VISIT RELATED TO AN AUTOMOBILE ACCIDENT OR WORK INJURY?

YES OR NO (CIRCLE) IF YES, DATE OF INJURY/ACCIDENT: _____ CLAIM#_____

ADJUSTER'S NAME: _____ PHONE#_____

PLEASE MAKE SURE WE HAVE YOUR OPEN CLAIM LETTER. YOU MUST HAVE THIS LETTER BEFORE YOU ARE SEEN BY THE PHYSICIAN. IF WE DO NOT HAVE YOUR OPEN CLAIM LETTER, IT IS YOUR RESPONSIBILITY TO CONTACT YOUR ADJUSTER/CLAIMS REPRESENTATIVE AND PROVIDE IT BEFORE YOUR APPOINTMENT OR YOU WILL BE ASKED TO RESCHEDULE.

IF YOU ARE NOT THE INSURANCE POLICY HOLDER, PLEASE COMPLETE THE INFORMATION BELOW:

NAME OF PRIMARY INSURANCE: _____

SUBSCRIBER NAME: _____ DOB: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD (CIRCLE) OTHER: _____

NAME OF SECONDARY INSURANCE: _____

SUBSCRIBER NAME: _____ DOB: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD (CIRCLE) OTHER: _____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PERMISSION TO GIVE MEDICAL INFORMATION

PATIENT NAME: _____

Δ **I DO NOT AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION**

******WHEN CHOOSING THIS OPTION, NO NEED TO FILL OUT REST OF FORM, JUST SIGN AT THE BOTTOM AND DATE******

Δ **I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING APPOINTMENT TIME, TEST RESULTS, MEDICATION AND/OR WRITTEN PRESCRIPTIONS, PROCEDURES, MEDICAL RECORDS AND/OR XRAYS. THIS INFORMATION MAY BE RELEASED TO:**

- SPOUSE: _____
- CHILD/CHILDREN: _____
- PARENT(S)/GUARDIAN: _____
- OTHER: _____

Δ **I AUTHORIZE MY MEDICAL DIAGNOSIS TO BE RELEASED TO THE FOLLOWING PHARMACY FOR THE DISPENSING OF MEDICATIONS:**

PHARMACY NAME: _____

IF A DELAY IN TREATMENT RESULTS BECAUSE WE CANNOT RELAY INFORMATION TO ANOTHER PARTY, DEARBORN ORTHOPEDICS & SPORTS MEDICINE, P.C. WILL NOT BE HELD RESPONSIBLE. BY SIGNING BELOW, YOU ACKNOWLEDGE A COPY OF OUR HIPAA POLICY IS AVAILABLE FOR YOUR REVIEW UPON REQUEST.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

REASON FOR VISIT

PATIENT NAME: _____ AGE: _____

PRIMARY CARE PHYSICIAN: _____ LOCATION: _____

HEIGHT: _____ FT. _____ IN. WEIGHT: _____ LBS.

WHAT IS THE AFFECTED BODY PART? _____ RIGHT/ LEFT/ BOTH (CIRCLE)

REASON FOR VISIT? Δ PAIN Δ SWELLING Δ STIFFNESS Δ NUMBNESS Δ WEAKNESS Δ SURGICAL FOLLOW-UP

WAS THERE AN INJURY? _____ IS THE INJURY RELATED TO WORK/ AUTO/ OTHER (CIRCLE)

PROBLEM BEGIN DATE/DATE OF INJURY: _____

CAUSE: _____

HAVE YOU TRIED ANY TREATMENTS FOR THIS PROBLEM? YES OR NO (CIRCLE)

Δ INJECTIONS: _____DATE OF LAST INJECTION

Δ SURGERY _____LIST TYPE & DATE

Δ MEDICATIONS: _____PLEASE SPECIFY TYPE/DURATION

Δ THERAPY/AT HOME EXERCISES _____DURATION

Δ BRACE Δ CANE Δ OTHER: _____EXPLAIN

WHAT MAKES THE PROBLEM WORSE?

Δ STANDING Δ WALKING Δ SITTING Δ BENDING Δ LIFTING Δ PUSHING Δ PULLING Δ STAIRS

Δ KNEELING Δ SQUATTING Δ TWISTING Δ OTHER: _____EXPLAIN

WHAT MAKES THE PROBLEM BETTER?

Δ ICE Δ HEAT Δ REST Δ ELEVATION Δ MEDICATION Δ OTHER: _____EXPLAIN

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE) (0 IS NONE AND 10 IS SEVERE)

THE PROBLEM IS: Δ IMPROVING Δ UNCHANGED Δ WORSENING

HAVE YOU HAD ANY RECENT TESTING FOR THIS PROBLEM? YES OR NO (CIRCLE)

Δ XRAYS (DATE OF XRAY & LOCATION) _____

Δ MRI (DATE OF MRI & LOCATION) _____

Δ EMG (DATE OF EMG & LOCATION) _____

Δ OTHER (EXPLAIN) _____

******PLEASE GIVE ANY IMAGING OR REPORTS TO THE FRONT DESK STAFF******

PATIENT/PARENT/GUARDIAN SIGNATURE: _____**DATE:** _____

MEDICAL HISTORY FORM

PATIENT NAME: _____

LIST ALL CURRENT MEDICAL PROBLEMS:

_____

_____

_____

LIST ALL SURGERIES FROM BIRTH TO PRESENT:

_____

_____

_____

LIST ANY BROKEN BONES FROM BIRTH TO PRESENT:

_____

_____

LIST ANY IMMEDIATE FAMILY MEMBER WITH A SIGNIFICANT MEDICAL PROBLEM, EXPLAIN:

_____

_____

DO YOU OR ANY IMMEDIATE FAMILY MEMBER HAVE DIFFICULTY UNDERGOING ANESTHESIA:
Δ YES Δ NO IF YES, EXPLAIN:

_____

SMOKING STATUS: Δ NON-SMOKER Δ FORMER SMOKER Δ CURRENT SMOKER

HISTORY OF DRUG ABUSE? Δ YES Δ NO **HISTORY OF ALCOHOL ABUSE?** Δ YES Δ NO

PLEASE SPECIFY: _____ **FREQUENCY:** _____

IF YOU HAVE ANY OF THE FOLLOWING, PLEASE MARK THE CORRESPONDING BOX AND EXPLAIN BELOW IF NECESSARY:

°CHILLS	°SKIN CANCER	°WHEEZING/ ASTHMA	°DIARRHEA	°LIVER DISEASE	°GOUT
°FEVER	°HIVES	°LEG SWELLING	°VENEREAL DISEASE	°ANEMIA	°ARTHRITIS
°NIGHT SWEATS	°BLURRED VISION	°HIGH BLOOD PRESSURE	°HIV/AIDS/HEPATITIS	°BRUISE/BLEED EASILY	°NUMBNESS
°WEIGHT LOSS	°HEADACHE	°HEART ATTACK	°DIFFICULT URINATION	°BLOOD CLOTS	°TINGLING
°WEIGHT GAIN	°HEARING LOSS	°HEART MURMUR	°HERNIA	°VARICOSE VEINS	°WEAKNESS
°CANCER/TUMOR	°SORE THROAT	°ULCERS	°DIABETES	°LEG CRAMPS	°DEPRESSION
°RASH	°COUGH	°HEARTBURN	°KIDNEY DISEASE	°JOINT PAIN	°TREMOR
°GROWTHS	°TUBERCULOSIS	°CONSTIPATION	°THYROID DISEASE	°JOINT SWELLING	°ABNORMAL PERIODS

EXPLANATION OF POSITIVE RESPONSES:

_____

_____

Δ MARK HERE IF ALL OF THE ABOVE IS NEGATIVE

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

DEARBORN ORTHOPEDICS & SPORTS MEDICINE, P.C.

23550 PARK ST STE 100

DEARBORN, MI 48124

(313)730-0500

PATIENT NAME: _____

PHARMACY NAME: _____ PHONE #: _____

PHARMACY ADDRESS: _____

ALLERGIES:	REACTION:

LIST OF MEDICATION(S):	DOSAGE:	QUANTITY:

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

FINANCIAL POLICY

DEAR PATIENT,

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE MEDICAL INSURANCE, WE WILL TRY TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. WE WILL BILL YOUR PRIMARY INSURANCE COMPANY AS A COURTESY TO YOU. PLEASE KEEP IN MIND, DUE TO THE MANY CHANGES IN INSURANCE POLICIES, IT IS NO LONGER AN EASY TASK TO INTERPRET EACH INDIVIDUAL POLICY. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE**. THIS INCLUDES ANY DEDUCTIBLES, CO-PAYS, AND CO-INSURANCES. FAILING TO COMPLY COULD RESULT IN YOU, THE PATIENT, BEING RESPONSIBLE FOR ANY AND ALL COSTS INCURRED.

***PLEASE REMEMBER, YOUR INSURANCE CONTRACT IS BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. ALL CO-PAYS, DEDUCTIBLES AND PAST DUE BALANCES ARE DUE AT THE TIME OF CHECK-IN. WE ACCEPT CASH, CHECK, OR VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND MONEY ORDERS.**

WE DO NOT ACCEPT ANY **STATE-FUNDED/MIHEALTH INSURANCE PLANS,** EVEN IF SECONDARY TO YOUR PRIMARY INSURANCE. YOU WILL BE RESPONSIBLE FOR ANYTHING YOUR PRIMARY PLAN DOESN'T COVER. WE WILL ONLY BILL THESE PLANS IF YOU ARE FOLLOWING UP FROM A SURGICAL PROCEDURE FROM THE HOSPITAL BY ONE OF OUR PHYSICIANS. THIS WOULD FALL UNDER CONTINUITY OF CARE AND IT IS FOR 90 DAYS AFTER YOUR SURGICAL PROCEDURE ONLY. AFTER THAT, YOU MUST FOLLOW UP WITH A PROVIDER WHO ACCEPTS YOUR PLAN. IF YOU ARE ENROLLED IN THE QMB PROGRAM FOR MEDICARE PART A & B, WE WILL FOLLOW ALL FEDERAL LAWS AND GUIDELINES.

IF YOU HAVE AN **HMO INSURANCE** THAT REQUIRES A REFERRAL, YOU MUST HAVE THE REFERRAL AT THE TIME OF YOUR VISIT, OBTAINING THE REFERRAL IS THE PATIENT'S RESPONSIBILITY. IF THE REFERRAL IS NOT AVAILABLE AT THE TIME OF YOUR VISIT, YOU WILL BE ASKED TO RESCHEDULE YOUR APPOINTMENT UNTIL SUCH A TIME THAT THE REFERRAL IS AVAILABLE FROM YOUR PRIMARY CARE PHYSICIAN.

IF YOU HAVE **WORKER'S COMPENSATION** OR AN **AUTOMOBILE CLAIM**, IT IS YOUR RESPONSIBILITY TO MAKE SURE WE HAVE AN AUTHORIZATION / OPEN CLAIM LETTER FROM YOUR CLAIMS ADJUSTER. IF THIS IS NOT AVAILABLE AT THE TIME OF YOUR VISIT, YOU WILL BE ASKED TO RESCHEDULE. IF YOUR CLAIM IS CLOSED OR IN DISPUTE, YOU, AS THE PATIENT, WILL BE RESPONSIBLE FOR THE PAYMENT.

IF YOU ARE **SELF-PAY** OR WITHOUT HEALTH INSURANCE COVERAGE, YOU WILL BE EXPECTED AND REQUIRED TO PAY ANY COST ASSOCIATED WITH YOUR TREATMENT AT THE TIME SUCH SERVICES ARE RENDERED.

CHARGE FOR CANCELLED APPOINTMENTS: THERE IS A $25.00 CHARGE FOR CANCELLED APPOINTMENTS, IF YOU GIVE US LESS THAN A 24-HOUR NOTICE.

CHARGE FOR "NO SHOW" APPOINTMENTS: THERE IS A $25.00 CHARGE FOR **ALL** SCHEDULED APPOINTMENTS THAT YOU DO NOT SHOW FOR.

COMPLETION OF FMLA/DISABILITY FORMS: PLEASE NOTE....FORMS REQUIRE A MINIMUM OF 7-10 BUSINESS DAYS TO COMPLETE. THERE IS A $10.00 FEE PER FORM. THE FEE IS REQUIRED BEFORE ANY PAPERWORK IS COMPLETED. THIS INCLUDES PAPERWORK RECEIVED VIA FAX, MAIL, OR IN PERSON.

X-RAY COPIES: ALL X-RAY COPIES ARE BURNED ONTO A CD. THEY ARE $5.00 EACH.

MEDICAL RECORDS: THE FEE IS DETERMINED BY THE AMOUNT OF MEDICAL RECORDS THAT ARE REQUESTED.

RETURNED CHECK FEE IS $35.00 (IN ADDITION TO THE INSUFFICIENT FUNDS AMOUNT)

COLLECTION ADMINISTRATION FEE: ANY ACCOUNT SENT TO COLLECTIONS WILL BE SUBJECT TO A $30.00 ADMINISTRATION FEE ON TOP OF THE BALANCE OWED. PLEASE CALL OUR OFFICE AND MAKE ARRANGEMENTS TO MAKE MONTHLY PAYMENTS TO KEEP YOUR ACCOUNT IN GOOD STANDING. WE ARE WILLING TO WORK WITH YOU.

I UNDERSTAND AND AGREE, REGARDLESS OF INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR SERVICES RENDERED. I HAVE READ ALL THE INFORMATION AND CERTIFY THAT ALL INFORMATION THAT I HAVE GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL IMMEDIATELY NOTIFY YOU OF ANY CHANGES IN MY HEALTH INSURANCE STATUS OR ANY OTHER PERTINENT INFORMATION.

I HEARBY AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE CARRIERS. I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS.

_____ **DATE:** _____

PATIENT/PARENT/GUARDIAN SIGNATURE

_____ **DATE:** _____

WITNESS