ASSOCIATED ORTHOPEDISTS OF DETROIT, P.C.

EDWARD S. JEFFRIES, M.D.; MICHAEL R. DEMERS, M.D.; STEVEN J. CUSICK, M.D.; KENNETH R. CERVONE, M.D.;
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50505 SCHOENHERR ROAD, SUITE 120
SHELBY TOWNSHIP, MI. 48315
(586) 412-1411
(586) 412-4626 (FAX)

Patient Name: _____Date of Birth_____Age:_____
Address: _____

City/State/Zip: _____SSN:_____

Primary Phone#:_____Secondary Phone#:_____Work Phone#:_____

Marital Status: M / S / W / D Sex: M / F Appt. with Doctor: _____

Emergency Contact: _____Primary Phone#:_____

Secondary Phone#:_____

(Please do NOT use your Home phone number for the Emergency Contact!!!!)

Family Physician/Internist: _____Office Phone#:_____
Did your Family Physician/Internist refer you to us? ☐ Yes ☐ No
If no, please list who referred you: _____
Pharmacy Name: _____Pharmacy Phone#:_____

Insurance Information

Primary Insurance Name: _____Subscriber Name: _____D.O.B._____
SSN: _____ Insured's Employer: _____Retired? Y N
Secondary Insurance Name: _____Subscriber Name: _____D.O.B._____
SSN: _____ Insured's Employer: _____Retired? Y N
Responsible Party Information (if other than patient)
Name: _____SSN:_____
Address (if different):_____
Relationship to Patient: _____Employer:_____D.O.B:_____

Do you believe your condition is *WORK* related? ☐ Yes ☐ No *If Yes what is your Claim #_____
Is your injury the result of an *AUTO* related injury? ☐ Yes ☐ No *If Yes what is your Claim #_____
Do you have coordination of benefits with your auto coverage for health insurance? ☐ Yes ☐ No
Do you have HMO insurance? ☐ Yes ☐ No IF YES, YOU MUST HAVE YOUR REFERRAL OR YOUR APPOINTMENT WILL BE CANCELLED.

****You MUST provide us with the insurance information at the time of your appointment for any WORK, AUTO and/or LIABILITY injury in order to be seen. According to insurance guidelines, which we MUST follow, we may NOT bill health insurance for these types of injuries, unless a special coordination of benefits exist with your health insurance.**

I authorize Associated Orthopedists of Detroit, PC to release any medical information necessary to process my insurance claim and I authorize payment of medical benefits be made to Specialists in Orthopedic Surgery for services rendered. I agree to pay my Co-pays, deductibles and any balance that is denied or in dispute by my Insurance Company.

SIGNATURE: _____DATE:_____
(PATIENT, PARENT OR RESPONSIBLE PARTY)
RELATIONSHIP TO PATIENT, IF OTHER THAN SELF: _____

NAME: _____ **D.O.B.** _____

We require that you specify whether or not you believe your medical problem IS or IS NOT related to a specific injury, so that your insurance claim for medical services rendered may be properly processed.

HISTORY OF PRESENT ILLNESS:

My medical problem ☐ IS ☐ NOT related to an injury?

What area of the body is to be examined today? _____ (be specific-i.e. right knee)

When did your injury or onset of symptoms begin? _____/_____/_____ (date of injury)

Please describe how this injury occurred: _____

_____

_____

Where did your injury occur?
- ☐ Home
- ☐ Work If yes. Have you reported your condition to your employer? ☐ Yes ☐ No
- ☐ MVA (AUTO) if yes. Have you reported the accident/injury to your Auto Insurance?
- ☐ Other: _____ (Please be specific)

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Student ☐ Retired

Are you currently working? ☐ Yes ☐ No-Last day: _____ ☐ Unemployed ☐ Disabled

Reason for not working: _____

CURRENT MEDICAL CONDITIONS:

Hand dominance: ☐ Right ☐ Left Height: _____ Weight: _____

Please list all allergies: Do you have any metal Allergies ☐ Yes ☐ No ☐ No allergies

_____

_____

Anemia	Y	N	Emphysema	Y	N	Heart Problems	Y	N	Polio	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Hepatitis A/B/C	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Fibromyalgia	Y	N	Hiatal Hernia	Y	N	Scoliosis	Y	N
Bladder/Prostate Problems	Y	N	Headache/Migraine	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Blood Clots	Y	N	Gall Bladder	Y	N	Kidney Disorder	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Head Injury	Y	N	Liver Disease/Jaundice	Y	N	Thyroid Disorder	Y	N
*Cancer	Y	N	Hearing Problems	Y	N	Meningitis	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Heart Attack	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N
Cholesterol	Y	N	Heart Catheterizations	Y	N	Pneumonia	Y	N	Weakness/Paralysis	Y	N

*If you answered Yes to Cancer, what Type? _____

_____

DO YOU HAVE ANY MEDICAL CONDITIONS NOT LISTED ABOVE? (PLEASE LIST):_____

_____

_____

NAME:_____ **D.O.B.**_____

PLEASE CIRCLY "Y" OR "N" FOR ANY CONDITIONS <u>YOUR FAMILY</u> SUFFERS FROM:

Anemia	Y	N	Emphysema	Y	N	Heart Problems	Y	N	Polio	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Hepatitis A/B/C	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Fibromyalgia	Y	N	Hiatal Hernia	Y	N	Scoliosis	Y	N
Bladder/Prostate Problems	Y	N	Headache/Migraine	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Blood Clots	Y	N	Gall Bladder	Y	N	Kidney Disorder	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Head Injury	Y	N	Liver Disease/Jaundice	Y	N	Thyroid Disorder	Y	N
*Cancer	Y	N	Hearing Problems	Y	N	Meningitis	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Heart Attack	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N
Cholesterol	Y	N	Heart Catheterizations	Y	N	Pneumonia	Y	N	Weakness/Paralysis	Y	N

<u>MEDICATIONS:</u> (Please List All Medications with dosages to include Prescriptions, Vitamins, Herbal, etc.) ☐ NONE
(BRING MEDICATION BOTTLES WITH YOU IF YOU NEED ASSISTANCE)

_____
_____
_____
_____

<u>SURGICAL HISTORY</u> (Please list the type of surgery, body part, and date or year of surgery)

_____
_____
_____
_____

<u>SOCIAL HISTORY:</u>

- Do you smoke? ☐ Yes ☐ No How much? _____per day For How long? _____
- Have you quit smoking? ☐ Yes ☐ No When? _____
- Do you drink alcohol? ☐ Yes ☐ No How much? ☐ Socially ☐ Weekly ☐ Daily ☐ Monthly ☐ Rarely
- Is there a chance you could be pregnant? ☐ Yes ☐ No Date of Last Menstrual Period_____
- Do you have AIDS/HIV? ☐ Yes ☐ No Have you ever been tested? ☐ Yes ☐ No
- Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
- Do You live in a: ☐ 1 story ☐ 2 story ☐ Condo ☐ House ☐ Apartment ☐ Alone ☐ w/family ☐ w/friends
- Do you use recreational drugs? ☐ Yes ☐ No what type? _____
- Do you use marijuana? ☐ Yes ☐ No ☐ Recreational ☐ Medically Prescribed
- Do you use any assisted devices? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ None

NAME:_____ **D.O.B.**_____

Do you now or have you recently had any problems related to the following systems? Circle "Yes" or "No". If you mark yes to any of the following, please indicate which doctor is treating you for that problem. If you have not seen a physician yet, please contact your Internist or Family Physician to address these issues.

ALLERGIC/IMMUNOLOGICAL:

HAY FEVER	YES	NO
DRUG ALLERGIES	YES	NO
ALLERGIC SEIZURE	YES	NO

OTHER: _____

CARDIOVASCULAR:

CHEST PAIN	YES	NO
VARICOSE VEINS	YES	NO
LEG SWELLING	YES	NO
IRREGULAR HEARTBEAT	YES	NO

OTHER: _____

CONSTITUTIONAL SYMPTOMS:

FEVER	YES	NO
CHILLS	YES	NO
HEADACHE	YES	NO

OTHER: _____

EAR/NOSE/THROAT/MOUTH:

EAR PROBLEMS	YES	NO
SORE THROAT	YES	NO
SINUS PROBLEM	YES	NO

OTHER: _____

ENDOCRINE:

EXCESSIVE THIRST	YES	NO
TOO HOT/COLD	YES	NO
TIRED/SLUGGISH	YES	NO

OTHER: _____

EYES:

BLURRED VISION	YES	NO
DOUBLE VISION	YES	NO
PAIN	YES	NO

OTHER: _____

GASTROINTESTINAL:

ABDOMINAL PAIN	YES	NO
NAUSEA/VOMITING	YES	NO
INDIGESTION/HEARTBURN	YES	NO

OTHER: _____

GENITOURINARY:

URINE RETENTION	YES	NO
PAINFUL URINATION	YES	NO
URINARY FREQUENCY	YES	NO

OTHER: _____

HEMATOLOGICAL/LYMPHATIC:

SWOLLEN GLANDS	YES	NO
BLOOD CLOTTING PROBLEMS	YES	NO

OTHER: _____

INTEGUMENTARY:

SKIN RASH	YES	NO
BOILS	YES	NO
PERSISTENT ITCH	YES	NO

OTHER: _____

MUSCOSKELETAL:

JOINT PAIN	YES	NO
NECK PAIN	YES	NO
BACK PAIN	YES	NO

OTHER: _____

NEUROLOGICAL:

SEIZURES	YES	NO
TREMORS	YES	NO
DIZZY SPELLS	YES	NO

OTHER: _____

PSYCHOLOGICAL:

DO YOU SUFFER FROM DEPRESSION?	YES	NO
DO YOU FEEL SEVERELY ANXIOUS OR NERVOUS?	YES	NO

OTHER: _____

RESPIRATORY:

WHEEZING	YES	NO
FREQUENT COUGH	YES	NO
SHORTNESS OF BREATH	YES	NO

OTHER: _____

PATIENT'S SIGNATURE: _____DATE:_____

AUTHORIZED REPRESENTATIVE SIGNATURE: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF (PHI) PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), Protected Health Information, under federal health privacy law, as described below.

I, _____authorize Associated Orthopedists of Detroit, P.C. to release and obtain my private health information to/from (check all that applies):

☐ My spouse/partner — Name of spouse/partner: _____

☐ My Primary Care Physician/Staff — Name of Physician: _____

☐ My Pharmacy — Name of Pharmacy: _____

☐ My Parent/Child(ren) — Name: _____

☐ My Personal Representative — Name of Representative: _____

☐ Other — Name: _____

☐ Other — Name: _____

☐ None of the above.

May our office leave a message on your answering machine/voicemail? ☐ Yes ☐ No

Are there any restrictions on PHI to be disclosed? ☐ Yes ☐ No

If Yes: _____

_____

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with Associated Orthopedists of Detroit, P.C. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Edwin Padilla, CMA 24715 Little Mack Ave. #100, St. Clair Shores, Mi. 48080. I understand that my revocation will not affect any actions taken by Associated Orthopedists of Detroit, P.C. prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating Protected Health Information for disclosure to a third party. This authorization shall be effective one year from the date signed. At which time this authorization to obtain and release this Protected Health Information expires.

Patient Signature/Authorized Representative: _____

Print Patient's Name: _____

Date: _____