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Abbas Zand, M.D.  
Bone Density Center

## New Patient Request

IF YOU RECEIVE THIS FAX IN ERROR OR THERE IS A PROBLEM WITH ITS TRANSMISSION,  
PLEASE CONTACT EAST LANSING ORTHOPEDICS AT (517)394-3200

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(First, M.I., Last)

Parent/Guardian for minor child: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number, Street, City, and Zip code)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Insurance Coverage: \_\_\_\_\_

**\*\*\*Worker's Comp and Medicaid HMO Plans require prior written authorization  
before an appointment is scheduled; please include with request \*\*\***

Requesting Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Requesting to:  Detrisac  McDermott  Zand  
 Hornbach  Morrison  Bone Density Test  
 McCardel  Uitvlugt

Diagnosis: \_\_\_\_\_  Right  Left  Bilateral

**\* WE DO NOT SEE ANY BACK, NECK OR RIB PROBLEMS \***

Date of Injury \_\_\_\_\_ Any previous surgery?  Yes  No (Include any copies of test results or surgeries)

Patient needs to be seen:  Urgent (1-2 days)  ASAP (1 week)  Next available (1-3 weeks)

**Appointment scheduled on: Date: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm**

**By: \_\_\_\_\_ With Dr. \_\_\_\_\_**

**\* Please have patient bring X-rays and medical records to his/her appointment \***