

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**Patient Information**

**Patient Information**

Date of Birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Sex

Male Female

Marital Status

Single Married Other

Social Security Number

\_\_\_\_-\_\_\_\_-\_\_\_\_

Patient Goes By:

\_\_\_\_\_

Email Address

\_\_\_\_\_

**Why We Ask for Race and Ethnicity**

In compliance with the American Recovery and Reinvestment act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

I decline to provide this information

**Race (circle one)**

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian/Pacific Islander
- White

**Ethnicity (circle one)**

- Hispanic or Latino
- Non-Hispanic or Latino

**Language Preference (circle one)**

- English
- Spanish
- Other

**Contact Information**

Home Phone Number

\_\_\_\_-\_\_\_\_-\_\_\_\_

Work Phone Number

\_\_\_\_-\_\_\_\_-\_\_\_\_

Cell Phone Number

\_\_\_\_-\_\_\_\_-\_\_\_\_

Home Address

\_\_\_\_\_

Street

Apt, Suite, Bldg

City, State, Zip Code

**Emergency and Employment Info**

**Emergency Contact**

Name

\_\_\_\_\_

Phone Number

\_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship to Patient

\_\_\_\_\_

**Patient's Employment Status**

Employment Status (circle one)

- Full Time Employed Full Time Student Unemployed
- Part Time Employed Part Time Student Retired

Patient's Occupation

\_\_\_\_\_

Patient's Employer

\_\_\_\_\_

Employer Phone Number

\_\_\_\_-\_\_\_\_-\_\_\_\_

Employer Address

\_\_\_\_\_

Street

Suite/Bldg

City, State, Zip Code

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

### Other Information

Family Physician

Do you have a primary care physician?

Yes No

Physician Name

Physician Address

Physician Phone Number

Referring Physician

Were you referred to us by a physician?

Yes No

Physician Name

Physician Address

Physician Phone Number

Preferred Local Pharmacy

Pharmacy Name

Pharmacy Address

Pharmacy Phone Number

### Financially Responsible Person

Is the patient the guarantor for this account? (circle Yes or No below)

Yes - If yes, skip to Primary Insurance section of the form.

No - If no, complete the information below.

Guarantor Name

Relationship to Patient (circle one)

Spouse Child Parent Other

Guarantor Address

Street

Apt, Suite, Bldg

City, State Zip Code

Guarantor Primary Contact Phone Number

Guarantor Secondary Contact Phone Number

Guarantor Social Security Number

Guarantor Birth Date

Guarantor Employer

Street

Suite/Bldg

City, State, Zip Code

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

### Primary Insurance

Type of Insurance (circle one)

Health Insurance    Workers' Compensation    No-Fault (Auto)    Other    Date of Injury: \_\_\_\_\_

Primary Insurance Carrier Name

Policy Holder Name

Policy Number

Relationship to Patient (circle one)

Self Spouse Parent Child Other

Group Number

Policy Holder Date of Birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder Employer

Policy Holder Social Security Number

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to East Lansing Orthopedic Association for any orthopedic services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

I understand and give my consent to the above terms.

### Secondary Insurance

Second Insurance Carrier Name

Policy Holder Name

Policy Number

Relationship to Patient (circle one)

Self Spouse Parent Child Other

Group Number

Policy Holder Date of Birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder Employer

Policy Holder Social Security Number

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to East Lansing Orthopedic Association for any orthopedic services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

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### Tertiary Insurance

Tertiary Insurance Carrier Name

Policy Holder Name

Policy Number

Relationship to Patient (circle one)

Self Spouse Parent Child Other

Group Number

Policy Holder Date of Birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder Employer

Policy Holder Social Security Number

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to East Lansing Orthopedic Association for any orthopedic services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

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### Patient Medical History

#### Patient Information

Height  
\_\_\_\_' \_\_\_\_"

Weight  
\_\_\_\_\_ lbs

#### Chief Complaint

Reason for visit?  
\_\_\_\_\_

Have you been treated for this problem before?  
YES NO

Date of Occurrence  
\_\_\_\_/\_\_\_\_/\_\_\_\_

Which of the following does your current problem relate to?

Car Accident Work Accident Other \_\_\_\_\_

#### Pain Scale

If you are having pain, please rate the intensity of your pain on a scale of 1-10 (circle one)

No Pain – 0 1 2 3 4 5 6 7 8 9 10 – Extreme Pain

#### Medical History

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

NONE

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acid Reflux                 | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Arthritis                         |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Birth Defects        | <input type="checkbox"/> Bladder Problems                  |
| <input type="checkbox"/> Bleeding or Bruising        | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Diabetes                          |
| <input type="checkbox"/> DVT/Blood Clots             | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Gallbladder Problems              |
| <input type="checkbox"/> Gastric Ulcer               | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Heart Attack                      |
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> HIV/AIDS                          |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Intestinal/Bowel Problems         |
| <input type="checkbox"/> Kidney Problems             | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Lung Problems                     |
| <input type="checkbox"/> Phlebitis                   | <input type="checkbox"/> MRSA/Staph Infection | <input type="checkbox"/> Osteoporosis                      |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Polio                | <input type="checkbox"/> Psychological Problems/Depression |
| <input type="checkbox"/> Pulmonary Embolism          | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Stroke/TIA                        |
| <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Thyroid Problems     |  |

Are there any other medical problems we should know about?  
\_\_\_\_\_  
\_\_\_\_\_

Are you right or left-hand dominant?  
Right Left Ambidextrous

Do you exercise or participate in sports regularly?  
YES NO

How often and what type of sports?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you or could you be pregnant? (circle one)  
YES NO

**Medications**

List all Medications you take, with or without a Prescription

I do not take any medications

Name	Dosage	Number Per Day	Reason
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

**Allergies**

Describe any current or past **DRUG ALLERGIES**

I have no drug allergies

Drug	Reaction	Treatment
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Describe any current or past **NON-DRUG ALLERGIES**

I have no non-drug allergies

Allergen	Reaction	Treatment
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**Surgeries and Hospitalization**

Have you had surgery or been hospitalized before?

YES NO

For each surgery or hospitalization, please enter below:

Procedure	Year	Physician	Complications
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

**Family History**

Mother, Father, Grandparents, Brothers or Sisters been treated in past of currently receiving treatment for any of the following?

- |                                       |                                    |  |                                  |
|---------------------------------------|------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Alzheimer's  | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer        | <input type="checkbox"/> None    |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Gout      | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Sudden Death  |                                  |

**Social History**

Smoking Status (circle one)

Current every day smoker    Current some day smoker    Former smoker    Never smoker

\*What year did you start smoking? \_\_\_\_\_

\*What year did you quit smoking? \_\_\_\_\_

Do you drink alcoholic beverages?

YES NO

Do you use recreational drugs?

Yes No

**Review of System**

Please check the following symptoms you have experienced on a regular basis

**GENERAL**

- Fever
- Weight Change
- Hormonal Problems
- NONE

**CARDIOVASCULAR**

- Chest Pain
- Palpitations
- Fluid/Swelling in Extremities
- NONE

**KIDNEY/BLADDER**

- Painful Urination
- Frequent Urination
- Incontinence
- NONE

**EYES**

- Glasses/Contacts
- Cataracts
- Glaucoma
- NONE

**RESPIRATORY**

- Shortness of Breath
- Sleep Apnea
- Wheezing
- NONE

**EARS, NOSE, THROAT**

- Difficulty Swallowing
- Ear Pain
- Seasonal Allergies
- Hard of hearing
- NONE

**GASTROINTESTINAL**

- Heartburn
- Diarrhea/Constipation
- Abdominal Pain
- Nausea/Vomiting
- NONE

**SKIN**

- Rashes
- Lumps
- NONE

**HEMATOLOGIC/LYMPHATIC**

- Anemia
- Blood Problems
- Lymph Problems
- NONE

**NEUROLOGICAL**

- Headaches
- Numbness
- Tingling
- Seizures
- Weakness
- NONE

**PSYCHOLOGICAL**

- Anxiety
- Depression
- Mood Swings
- NONE

**Patient Consents**

**Patient Acknowledgment and Consent**

With my consent, East Lansing Orthopedic Association may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to East Lansing Orthopedic Association’s Notice of Privacy Policy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices, including revisions effective September 23, 2013, prior to signing this consent. East Lansing Orthopedic Association reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to East Lansing Orthopedic Association Privacy Officer at 3394 E. Jolly Rd. Ste. A, Lansing, MI 48910.

With my consent, East Lansing Orthopedic Association may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, cards and patient statements.

I have the right to request that East Lansing Orthopedic Association restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to East Lansing Orthopedic Association’s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures to reliance upon my prior consent. If I do not sign this consent, East Lansing Orthopedic Association may decline to provide treatment to me.

I understand that East Lansing Orthopedic physicians prescribe medications electronically, as permitted, to the pharmacy. Additionally, East Lansing Orthopedic Association will obtain the history of all my past prescriptions and I understand that those prescriptions will become a part of my electronic health record.

**I understand that I am financially responsible to pay any deductible and/or co-pay. I understand if I do not have any health insurance or have any uncovered benefits I am financially responsible for the entire balance for all medical and surgical care rendered.**

I acknowledge that I am hereby made aware of the East Lansing Orthopedic Association, P.C. Privacy Policy and that a copy was available for my review.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date