Print Form

Call – 586.627.1100

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Center for Orthopedic Surgery

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21550 Harrington, Suite A
Clinton Township, MI 48036

Welcome to the Center for Orthopedic Surgery!

We are committed to serving you promptly and professionally. We do however need your help. In order for our office to properly evaluate your problem as well as facilitate the billing process, we ask your cooperation in providing us with accurate information about your health as well as insurance coverage.

The forms needed are on the proceeding pages of this document this gives you an opportunity to complete much of this information at home where you have access to your personal records. On the day of your appointment, we will need to verify that this information is accurate but ***no more forms!!***

How Do You get the forms back to us?

1- The forms are writable so you can email them to us at registration@ortho-surgery.com or use the submit button on the last page of the form.

2- Or you can print the completed forms and fax them to us at 586-627-1120

3- Or you can mail them to us at COS 21550 Harrington Suite A, Clinton Twp, MI. 48036

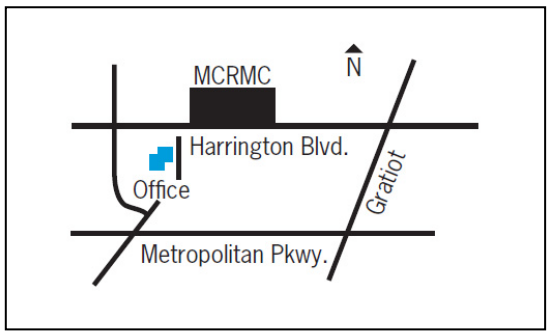
4- Bring completed form with you to appt. (This may hold up your appointment time, but is still faster than filling out the forms in the office)

Please be sure to get this information to us as soon as possible so we can be ready for you.

Patient Checklist for Day of Appointment

* Please have the online registration form completed if not emailed, faxed or mailed.
* Personal identification (photo ID) such as driver's license.
* Current insurance card.
* Referral or prescription if insurance requires (HAP, HMO, BCN, Mcare, etc.)
* Parent/guardian if less than 18 years of age.
* For a lower extremity problem (hip/knee/leg/ankle) you may bring shorts or wear clothing that can be easily removed for your examination.
* For an upper extremity problem (neck/shoulder/elbow/forearm) you will want to wear a tank top or t shirt that allows access to your affected area.
* Any current X-rays.
* Any MRI or other imaging studies for area of concern.

We thank you for your cooperation and understanding.



Patient Information Form

Today's Date:_____

Patient Name: Mr/Ms/Mrs/Dr _____
☐ ☐ ☐ ☐ First Last Middle Initial

Home Address:_____ **Apt:** _____

City: _____ **Zip**: _____ **Do You Reside in a Nursing Home?** ☐ YES ☐ NO

Home Phone:_____ **Work Phone**:_____ Ext_____**Other Phone**:_____
☐ Cell ☐ Pager ☐ Fax ☐ Other

Preferred Phone: ☐ Home ☐ Work ☐ Other Email: _____ **Sex**: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Birth Date: _____ **SSN**: _____ **Employer:** _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Active Military

Preferred Language: _____ **Ethnicity**: ☐ Hispanic ☐ Non-Hispanic **Race**:_____

Primary Care Physician: _____**Phone**:_____

Physicians Address: _____

Insurance Information

Effective Date: _____ Insurance Company: _____

Who holds the insurance: ☐ Self ☐ Spouse ☐ Child ☐ Other **If self skip this section, otherwise please complete.*

Name: _____ **Date of Birth**: _____
First Last Middle Initial

SSN: _____ **Sex**: ☐ Male ☐Female **Email**:_____

Home Address: ☐ Same as Patients / OR

_____
Address City State Zip

Home Phone:_____ **Work Phone**:_____Ext_____ **Other Phone**:_____
☐ Cell ☐ Pager ☐ Fax ☐ Other

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Active Military

Is this visit related to a workers compensation injury? ☐ **YES** ☐ **NO**
Is this visit related to an injury from an auto accident? ☐ **YES** ☐ **NO**
Is this Visit for an injury with a pending legal claim? ☐ **YES** ☐ **NO**
Is this claim related to an injury? ☐ **YES** ☐ **NO**
**If yes answered to any of the above questions – Accident information form required.*

Patient's Name: _____ Date of Birth: _____

*****Only complete this page if you have more than one insurance carrier.*****

If you only have one insurance than proceed to next page.

Secondary Insurance Information

Insurance Company: _____

Contract/ Policy/ ID # : _____ **Group**: _____ **Effective Date**: _____

Patient Student Status: ☐ Not a Student ☐ Full Time Student ☐ Part Time Student Attending: _____

Who holds the insurance: ☐ *Self ☐ Spouse ☐ Child ☐ Other **If self is checked skip this section, otherwise please complete.*

Name: _____ **Date of Birth**: _____
First Last Middle Initial

SSN: _____ **Sex**: ☐ Male ☐ Female **Email**:_____

Home Address: ☐ Same as Patients / OR

_____
Address City State Zip

Home Phone:_____ **Work Phone**:_____Ext_____ **Other Phone**:_____
☐ Cell ☐ Pager ☐ Fax ☐ Other

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Self Employed ☐Retired ☐Active Military

Insurance Company: _____

Contract/ Policy/ ID # : _____ **Group**: _____ **Effective Date**: _____

Patient Student Status: ☐ Not a Student ☐ Full Time Student ☐ Part Time Student Attending: _____

Who holds the insurance: ☐ *Self ☐ Spouse ☐ Child ☐ Other **If self is checked skip this section, otherwise please complete.*

Name: _____ **Date of Birth**: _____
First Last Middle Initial

SSN: _____ **Sex**: ☐ Male ☐ Female **Email**:_____

Home Address: ☐ Same as Patients / OR

_____
Address City State Zip

Home Phone:_____ **Work Phone**:_____Ext_____ **Other Phone**:_____
☐ Cell ☐ Pager ☐ Fax ☐ Other

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Self Employed ☐Retired ☐Active Military

If Medicare Secondary Check Reason:
☐ Working Aged Beneficiary or Spouse with Employer Group Health Plan
☐ End-Stage Renal Disease Beneficiary
☐ No-fault Insurance including Auto is Primary
☐ Black Lung
☐ Disabled Beneficiary Under Age 65 with Large Group Health Plan
☐ Other Liability Insurance is Primary

Patient Name:_____ **Date of Birth:**_____

Patient History Form

Height:_____ Weight:_____ Occupation:_____

Current Symptoms:

Current problem for this evaluation:_____

Body area (arm/leg/back/etc): _____ ☐ Right ☐ Left ☐ Both

When did your problem begin?_____

Have you had any treatment / x-rays? ☐ YES ☐ NO If yes, when?_____

By whom?_____Where?_____

Is this problem related to an injury? ☐ YES ☐ NO

Current Medications: *Even if you are not currently taking any medications please provide the name of your preferred pharmacy so that we may better serve you.*

Pharmacy: _____ **Phone**: _____

Pharmacy Location:_____

Current List of ALL Medications You are Currently Taking - INCLUDING OVER THE COUNTER:

Name Of Medication:	Strength:	Dosage:

List ALL DRUG ALLERGIES:_____

_____

Life Style

Physical Activity: ☐ Inactive ☐ Sedentary ☐ Moderately Active ☐ Extremely Active

Caffeine: ☐ Coffee ☐ Tea Amount/Day _____Amount/Week_____

Tobacco: ☐ Cigar ☐ Cigarettes ☐ Smokeless Tobacco Amount/Day_____Amount/Week_____

Alcohol: ☐ Beer ☐ Wine ☐ Other_____ Amount/Day _____Amount/Week_____

Other Substances: List:_____

Patient Name:_____**Date of Birth:**_____

Review Of Systems *Please check all that apply.*

Constitutional:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Other_____

Eyes:
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Headache
- ☐ Visual Changes
- ☐ Eye Pain
- ☐ Other_____

ENMT:
- ☐ Dry Mouth
- ☐ Ear Pain/Pressure
- ☐ Altered Sense of Smell
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Neck Pain/Stiffness
- ☐ Mouth Pain
- ☐ Post Nasal Drainage
- ☐ Sinus Pain/Pressure
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ Trouble Swallowing
- ☐ Other_____

Cardiovascular:
- ☐ Hypertension
- ☐ Chest Pain
- ☐ Palpitation
- ☐ Fainting
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Atrial Fibrillation
- ☐ Other_____

Skin:
- ☐ Color Changes
- ☐ Dry Skin
- ☐ Knots/Skin Nodules
- ☐ Rashes
- ☐ Itchy Skin
- ☐ Skin Lesions
- ☐ Skin Ulcers
- ☐ Cellulitis
- ☐ Eczema
- ☐ Other_____

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Blood in Stools
- ☐ Trouble Swallowing
- ☐ Rectal Pain
- ☐ Ulcer
- ☐ Nausea/Vomiting
- ☐ Weight Change
- ☐ Hepatitis
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Reflux
- ☐ Other_____

Musculoskeletal: (Please indicate where)?
- ☐ Fracture_____
- ☐ Joint Instability_____
- ☐ Joint Pain_____
- ☐ Joint Swelling_____
- ☐ Joint Stiffness_____
- ☐ Muscle Weakness_____
- ☐ Muscle Pain_____
- ☐ Sprain_____
- ☐ Arthritis_____
- ☐ Tendonitis_____
- ☐ Osteoarthrosis_____
- ☐ Other_____

Respiratory:
- ☐ Shortness of Breath
- ☐ Productive Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Other_____

Neurological:
- ☐ Dizziness
- ☐ Double Vision
- ☐ Coordination Problems
- ☐ Extremity Weakness
- ☐ Problems Walking
- ☐ Headache
- ☐ Numbness
- ☐ Seizure
- ☐ Fibromyalgia
- ☐ Fainting
- ☐ Stroke
- ☐ Paralysis
- ☐ Other_____

Psychiatric
- ☐ Anxious
- ☐ Nervous
- ☐ Depressed
- ☐ Nervous Breakdown
- ☐ Stress
- ☐ Sleeplessness
- ☐ Drug/Alcohol
- ☐ ADD/ADHD
- ☐ Other_____

Endocrine:
- ☐ Diabetes
- ☐ Lump in Neck
- ☐ Change in Hair Growth
- ☐ Hypoglycemia
- ☐ Thyroid
- ☐ Excessive Hunger/Thirst
- ☐ Heat/Cold Intolerance
- ☐ Other_____

Vascular/Lymphatic:
- ☐ Anemia
- ☐ Bleeding Tendency
- ☐ Lymph Node Pain/Enlargement
- ☐ Transfusions
- ☐ Cold Hands/Feet
- ☐ Poor Circulation
- ☐ Swelling
- ☐ High Cholesterol
- ☐ Other_____

Allergic/Immunologic:
- ☐ Metal Allergies
- ☐ Malignant Hyperthermia
- ☐ Allergic to Latex
- ☐ Anaphylactic Reaction
- ☐ Other_____

Hematologic:
- ☐ Anemia
- ☐ Hemophilia
- ☐ Excessive Bleeding
- ☐ Pulmonary Embolism
- ☐ Deep Vein Thrombosis
- ☐ Leukemia
- ☐ Blood Clots
- ☐ Stroke
- ☐ Bleeding Tendencies
- ☐ Other_____

Patient Name:_____ **Date of Birth:**_____

Complete Personal Medical History

Have you had any serious illness? ☐ YES ☐ NO

If YES, please list:_____

_____

Past Surgeries? ☐ YES ☐ NO

If YES, please list:_____

_____

Overall Health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Family History: Does anyone of your close relatives (sisters, brothers, parents, grandparents, children, uncles, aunts) has/had any of the following diseases?

☐ Allergies ☐ Cancer ☐ Diabetes ☐ Venous Thrombosis
☐ Heart Attack ☐ Stroke ☐ Other chronic Diseases:_____

If any of your close relatives has died, at which age and from what cause has he or she died?

Mother	Age:	Cause of Death:
Father	Age:	Cause of Death:
Sister	Age:	Cause of Death:
Brother	Age:	Cause of Death:
Child	Age:	Cause of Death:
Grandmother	Age:	Cause of Death:
Grandfather	Age:	Cause of Death:

How did you hear about us?

☐ Physician:_____
☐ Phone Book
☐ Patient:_____
☐ Insurance Book
☐ Advertisement (where):_____
☐ Emergency Room or Hospital (which one):_____
☐ Other:_____

Certificate of Authenticity: I herby certify the above information is true and correct to the best of my ability.

Signed:_____Date:_____

Submit by Email Print Form