Patient Information

Patient Information

Name
_____

Sex
Male Female

Marital Status
Single Married Other

Date of Birth
___/____/_____

Email Address
_____

Social Security Number
_____-_____-_____

Patient Goes By:
_____

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

Primary Phone Number
_____-_____-_____

Secondary Phone Number
_____-_____-_____

Home Address
_____
Street Apt, Suite, Bldg City, State Zip Code

Emergency And Employment Info

Emergency Contact

Name
_____

Phone Number
_____-_____-_____

Relation
_____

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
_____

PATIENT NAME _____
DATE OF BIRTH _____

Other Information

Referring Physician
Were you referred to us by a physician?
Yes No

Physician Name
_____

Physician Phone Number
_____-_____-_____

Family Physician
Do you have a primary care physician?
Yes No

Physician Name
_____

Physician Phone Number
_____-_____-_____

Preferred Local Pharmacy
Pharmacy Name
_____

Pharmacy Phone Number
_____-_____-_____

Pharmacy Address
_____

Financially Responsible Person

Is the patient the guarantor for this account?
Yes No

If No, Guarantor Name
_____

Relationship to Patient (circle one)
Spouse Child Parent Other

Guarantor Primary Contact Phone Number
_____-_____-_____

Guarantor Secondary Contact Phone Number
_____-_____-_____

Guarantor Social Security Number
_____-_____-_____

Guarantor Birth Date
___/____/_____

Guarantor Employer
_____

Guarantor Address
_____
Street Apt, Suite, Bldg City, State Zip Code

PATIENT NAME _____
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 Number

_____

Group Number

_____

Policy Holder Name

_____

Relationship to Patient (circle one)

Self Spouse Parent Child Other

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 Orthopedics, for anesthesia and orthopedic surgical 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 Number

_____

Group Number

_____

Policy Holder Name

_____

Relationship to Patient (circle one)

Self Spouse Parent Child Other

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 Orthopedics, for anesthesia and orthopedic surgical 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.

Tertiary Insurance

Tertiary Insurance Carrier Name

_____

Policy Number

_____

Group Number

_____

Policy Holder Name

_____

Relationship to Patient (circle one)

Self Spouse Parent Child Other

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 Orthopedics, for anesthesia and orthopedic surgical 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 NAME _____

DATE OF BIRTH _____

Patient Medical History

Patient Information

Height
___’ ____”

Weight
_____ lbs

Chief Complaint

What brings you to see the doctor?
_____

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 _____

Medical History

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

□ Anemia	□ Arthritis	□ Asthma
□ Birth Defects	□ Bladder Problems	□ Bleeding or Bruising
□ Cancer	□ Diabetes	□ DVT/Blood Clots
□ Epilepsy	□ Gallbladder Problems	□ Gout
□ Heart Disease	□ Hepatitis	□ HIV/AIDS
□ High Blood Pressure	□ High Cholesterol	□ Intestinal/Bowel Problems
□ Kidney Problems	□ Liver Disease	□ Lung Problems
□ Phlebitis	□ MRSA/Staph Infection	□ Osteoporosis
□ Peripheral Vascular Disease	□ Polio	□ Psychological problems
□ Pulmonary Embolism	□ Rheumatic Fever	□ Sexually Transmitted Disease
□ Stroke/TIA	□ Tuberculosis	□ Thyroid Problem
□ Ulcer	□ NONE	

Are there any other medical problems we should know about?

_____

_____

Are you right or left-hand dominant?
Right Left

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

PATIENT NAME _____

DATE OF BIRTH _____

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.			
5.			

Surgeries and Hospitalization

Have you had surgery or been hospitalized before?

YES NO

Select the surgeries or hospitalizations you have had

□ Arthroscopy □ Joint Replacement □ Bone or Joint Reconstruction

□ Spine Surgery □ Other _____

For each surgery or hospitalization, please enter below:

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

PATIENT NAME _____

DATE OF BIRTH _____

Family History

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

□ Alzheimer's □ Arthritis □ Cancer □ None
□ Diabetes □ Gout □ Heart Disease □ Unknown
□ Osteoporosis □ Stroke □ 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?

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

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

PATIENT NAME _____

DATE OF BIRTH _____

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

PATIENT NAME _____

DATE OF BIRTH _____