

**ASSOCIATED ORTHOPEDISTS OF DETROIT, P.C.**

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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 CIRCLE "Y" OR "N" FOR ANY CONDITIONS YOUR FAMILY 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

**MEDICATIONS:** (Please List All Medications with dosages to include Prescriptions, Vitamins, Herbal, etc.)  NONE

(BRING MEDICATION BOTTLES WITH YOU IF YOU NEED ASSISTANCE)

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**SURGICAL HISTORY** (Please list the type of surgery, body part, and date or year of surgery)

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**SOCIAL HISTORY:**

- 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: \_\_\_\_\_

**GENITOURINARY:**

URINE RETENTION YES NO  
PAINFUL URINATION YES NO  
URINARY FREQUENCY YES NO  
OTHER: \_\_\_\_\_

**CARDIOVASCULAR:**

CHEST PAIN YES NO  
VARICOSE VEINS YES NO  
LEG SWELLING YES NO  
IRREGULAR HEARTBEAT YES NO  
OTHER: \_\_\_\_\_

**HEMATOLOGICAL/LYMPHATIC:**

SWOLLEN GLANDS YES NO  
BLOOD CLOTTING PROBLEMS YES NO  
OTHER: \_\_\_\_\_

**CONSTITUTIONAL SYMPTOMS:**

FEVER YES NO  
CHILLS YES NO  
HEADACHE YES NO  
OTHER: \_\_\_\_\_

**INTEGUMENTARY:**

SKIN RASH YES NO  
BOILS YES NO  
PERSISTENT ITCH YES NO  
OTHER: \_\_\_\_\_

**EAR/NOSE/THROAT/MOUTH:**

EAR PROBLEMS YES NO  
SORE THROAT YES NO  
SINUS PROBLEM YES NO  
OTHER: \_\_\_\_\_

**MUSCOSKELETAL:**

JOINT PAIN YES NO  
NECK PAIN YES NO  
BACK PAIN YES NO  
OTHER: \_\_\_\_\_

**ENDOCRINE:**

EXCESSIVE THIRST YES NO  
TOO HOT/COLD YES NO  
TIRED/SLUGGISH YES NO  
OTHER: \_\_\_\_\_

**NEUROLOGICAL:**

SEIZURES YES NO  
TREMORS YES NO  
DIZZY SPELLS YES NO  
OTHER: \_\_\_\_\_

**EYES:**

BLURRED VISION YES NO  
DOUBLE VISION YES NO  
PAIN YES NO  
OTHER: \_\_\_\_\_

**PSYCHOLOGICAL:**

DO YOU SUFFER FROM  
DEPRESSION? YES NO  
DO YOU FEEL SEVERELY  
ANXIOUS OR NERVOUS? YES NO  
OTHER: \_\_\_\_\_

**GASTROINTESTINAL:**

ABDOMINAL PAIN YES NO  
NAUSEA/VOMITING YES NO  
INDIGESTION/HEARTBURN YES NO  
OTHER: \_\_\_\_\_

**RESPIRATORY:**

WHEEZING YES NO  
FREQUENT COUGH YES NO  
SHORTNESS OF BREATH YES NO  
OTHER: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

AUTHORIZED REPRESENTATIVE SIGNATURE: \_\_\_\_\_

