



MEDICAL HISTORY

Date: _____

Patient Name: _____

Date of Birth: _____

Primary Care Physician: _____

Referring Physician: _____

Other Physician you want a report sent to: _____

Preferred Pharmacy (One that is not mail order): _____

Please list all medications:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

___ See attached list

Please list all allergies:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Please list all medical problems:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Please list all surgeries you have had:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.



MEDICAL HISTORY (Clinical 2)

Date: _____

Patient Name: _____

Date of Birth: _____

Do you or anyone in your family have:

- Anesthesia Reaction
- Bleeding Disorder
- Clotting Problems
- Rheumatoid Arthritis

Do you use recreational drugs? No Marijuana Cocaine Methamphetamine Heroin

Other _____

Tobacco: Current Former Never

Type _____ Years smoked _____ Packs/day _____ Pack years _____

Ever tried to quit? Yes No Year quit _____

Passive smoke exposure? Yes No

Smoker status (Meaningful Use)

- Current every day smoker
- Smoker, current status unknown
- Former smoker
- Current some day smoker
- Never smoker
- Unknown if ever smoked

Do you drink alcohol? None History of Alcoholism Less than 7 drinks a week More than 7 drinks a week

Exercise? Unable Sedentary Occasional Active Lifestyle Regular

Review of Systems All Normal

Constitutional

No Yes

Fever

Recent Weight Loss/Gain

Cardiovascular

No Yes

Chest Pain

Palpitations

Integumentary

No Yes

Rash

Skin Sores

Metabolic/Endocrine

No Yes

Excessive Thirst

Excessive Urination

HEENT

No Yes

Sore Teeth

Infected Teeth

Gastrointestinal

No Yes

Heartburn

Bloody Stools

Neurological

No Yes

Numbness/Tingle in Arms

Numbness/Tingle in Legs

Psychiatric

No Yes

Depression

Anxiety

Respiratory

No Yes

Shortness of Breath

Snoring

Genitourinary

No Yes

Frequent Urination

Burning Urination

Hematologic

No Yes

Easy Bruising

Easy Bleeding

Immunologic

No Yes

Sensitivity to Latex

Sensitivity to Metals

- No Yes Do you have a Cardiac Stent? No Yes Do you have a latex allergy?
- No Yes Have you had heart valve surgery?
- No Yes Are you currently taking any blood thinners (Plavix, Coumadin, etc.) or Aspirin?
- No Yes Do you have a history of DVT/PE (Blood clot in leg or lung)?
- No Yes Do you have a history of MRSA (Staph infection)? No Yes Do you have or think you may have a metal allergy?
- No Yes Are you on any Rheumatoid Arthritis drugs?
- No Yes Are you Diabetic?
- No Yes Do you have a history of Sleep Apnea? Patient Unable to Answer



CONSENT FORM

HIPAA Privacy Notice

I understand that, under Health Insurance Portability & Accountability Act of 1996 {HIPAA}, I have certain rights to privacy regarding my protected health information. Great Lakes Orthopaedic Center's *Notice of Privacy Practices* has been made available to me, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of this notice. In accordance with the *Notice of Privacy Practices*, I authorize Great Lakes Orthopaedic Center to administer medical care and surgical procedures. I understand medical information concerning my treatment may be released to my insurance carrier, referring and or primary physician.

Initial

Receipt of Payment Policy

I acknowledge the receipt of Great Lakes Orthopaedic Center's Payment Policy. I authorize Great Lakes Orthopaedic Center to directly bill my health insurance carrier(s) on my behalf to process insurance claims. I understand I am financially responsible for all co-payments, deductibles and non-covered services at the time of service. I further request direct payment from my health insurance carrier(s) to Great Lakes Orthopaedic Center, which accepts assignment of benefit.

Initial

Authorization to Release Information to Family/Friend

I authorize the physician/provider to release medical information, to include test results or any other medical findings, to family members/friends listed below:

Relationship: _____ Phone _____
(Print Name of Family Member/Friend)

Relationship: _____ Phone _____
(Print Name of Family Member/Friend)

Initial

Authorization to Treat

I hereby authorize the physician/provider in charge of the care of _____ to diagnose and treat as deemed advisable in the case of this patient. I have custody and /or responsibility for this patient.

Initial

Patient Name (Printed)

Date of Birth

Signature of Patient or Legal Guardian

Date

Printed Name of Legal Guardian

Relationship to Patient

Witness Signature (required only when signed with an X or patient/representative mark)



Great Lakes Orthopaedic Center PAYMENT POLICY

Thank you for choosing Great Lakes Orthopaedic Center for your Orthopaedic care. We are committed to building a successful physician-patient relationship with you. An important part of that relationship is understanding how payments for services are made and how we bill insurance.

Insurance Payments

We participate with the following insurance companies and/or government programs: Medicare, Blue Cross Blue Shield, Priority Health, Cofinity, ASR, Workman's Compensation, Tricare, Blue Care Network, and regular Michigan Medicaid (NOT Medicaid HMO Plans). We will submit insurance claims to these companies and accept the amounts they pay under their fee schedules. You will still be responsible for any co-pays or deductibles not covered by your insurance policy.

If we do not participate with your insurance company, we will submit your claim on your behalf as a courtesy and you are responsible for payment of ALL charges whether or not they are covered by your insurance policy.

If you do not have insurance coverage, payment in full is expected for office services at the time of service. For elective surgeries, a 50% deposit is required prior to surgery. If you have questions please contact our billing office prior to your appointment or scheduling surgery.

Patient Responsibilities

You are responsible to pay in full at the time of service for services not covered by insurance. Examples of these are co-pays, deductibles, balances not covered by your insurance policy, medical record copies, x-ray copies, disability forms, waterproof cast liners, and many braces and splints. We accept cash, check, MasterCard, Visa, Discover, debit card and CareCredit. CareCredit is a credit financing option for healthcare services.

You are responsible to sign a statement requesting that payment be made to our practice and authorizing Great Lakes Orthopaedic Center to release any information necessary to process your insurance claim.

You are responsible at the time of service to tell us if another party, apart from your insurance carrier, is responsible for paying for your treatment. Examples include: Secondary or supplemental insurance plans, coverage under a spouses plan, or services related to injuries from an auto accident or work injury.

You are responsible for notifying us of any changes in the following information: change in your insurance policy, drivers license, legal name, current address, employer name & address, social security number, birth date, and telephone numbers. You are responsible for providing us with a copy of any new insurance cards.

You are responsible for obtaining approvals, referrals or authorizations from your insurance carrier, workman's compensation insurance, auto insurance, or primary care physician when required under your insurance policy. These approvals, referrals or authorizations must be done before you can be seen in our office.

Guardians and parents of minor children are responsible for payment of their medical expenses. Patients brought to our office by persons other than the parent or legal guardian must have a signed authorization by the parent or legal guardian authorizing Great Lakes Orthopaedic Center to treat the patient.

If you cannot pay for services provided

We ask that you contact our billing office and speak to a representative whenever you have an insurance problem or cannot meet your financial obligation.

If you do not pay for services provided

Outstanding balances over 90 days will be turned over to our collection agency or attorney unless arrangements have been made in advance.

If you have questions please call us Monday thru Friday, 8 a.m. to 5 p.m. EST at (231)935-0900.