

Name:

Chart:

DOB:

Date:

Medicare Patient Information Form

Date of Birth _____ Social Security#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Spouse's Name: _____ Work Phone: _____ Cell Phone: _____

Primary Care: _____ Phone: _____

Whom may we contact in the case of an emergency?

_____ Phone: _____

Whom may we thank for referring you to us?

_____ Phone: _____

Who is responsible for this bill? _____

Did you sustain an injury at work? YES NO

Are you covered under an employer or union policy? YES NO

Are your injuries accident related? YES NO

Are you currently employed? YES NO

Have you ever served in the military? YES NO

Is your spouse or family member employed? YES NO

Do you have a secondary insurance policy? YES NO

Are you covered under any other healthcare plan? YES NO

Have you made any changes to your choice of Medicare options in the last open enrollment period? YES NO

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature _____

Date _____

Name:

Chart:

DOB:

Date:

PATIENT INFORMATION

Last Name _____ Legal First Name _____ Middle Initial _____
 Sex _____ Social Security # _____ Birth date _____
 Street Address _____ City, State, Zip _____ OK To Leave Msg ___
 Home Phone: _____ Work Phone: _____ Cell: _____
 Email Address _____ @ _____ Prefers To Be Called _____

Race Choices: White American Indian Black Asian Type-Unknown _____
 Ethnicity: Hispanic Origin Non-Hispanic Origin Type-Unknown _____
 Language Choices: English Chinese French Hebrew Hindi Japanese Portuguese
 Russian Yiddish Type - Unknown _____

SPOUSE INFORMATION

First Name _____ Last Name _____ Date of Birth _____
 Work Phone _____ Emergency Contact Person Same as Spouse
 Other Relationship _____

WHO REFERRED YOU TO THE OFFICE?

Dr. Name _____ Phone _____ Hospital _____
 Other _____

PRIMARY CARE PHYSICIAN:

Phone Number _____ Fax Number _____
 Address _____

**RESPONSIBLE PARTY INFORMATION
(PERSON'S NAME WHO APPEARS ON YOUR INSURANCE CARD)**

NOTE: If your name is not the primary name on the insurance card, you are NOT the responsible party

Name on Card: _____ Date of Birth _____ SSN# _____
 Address: _____ City _____ State _____ Zip _____
 Employer Name _____ Occupation _____
 Work Phone _____ Relationship _____

Attention Parents: It is the policy of this office that the parent who requests treatment for his/her child is responsible for all fees for service.

INSURANCE INFORMATION

PRIMARY INSURANCE

Blue Cross Blue Shield Medicare
 Medicaid Workers Comp
 Auto Other _____
 HAP

SECONDARY INSURANCE:

Blue Cross Blue Shield Medicare
 Medicaid Workers Comp
 Auto Other _____
 HAP

Name: _____

Chart: _____

Date: _____

ORTHOPAEDIC HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

Is the current problem the result of a(n) Car Accident Work Accident Other

Date of Injury: _____ Please Describe: _____

Person to notify in case of an emergency:

Name: _____ Relationship: _____ Phone: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

Primary Physician: _____ Address: _____

Referring Physician: _____ Address: _____

FAVORITE PHARMACY

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Name:

Chart:

Date:

PAST MEDICAL HISTORY

Please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes - Non-Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Other |

Have you ever had general anesthesia? No Yes

Have you or any member of your family ever had problems with anesthesia? No Yes Please describe: _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	DOCTOR/HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Grandfather (maternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Grandmother (paternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Grandfather (paternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Father	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Mother	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Other: _____	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____

Name:

Chart:

Date:

SOCIAL HISTORY

Occupation

- Full time
- Disabled
- Part time
- Not Employed
- Retired
- Student

Education

- Less than 8th grade
- High school
- 4 year college
- 2 year college
- Post graduate

Marital Status

- Married
- Divorced
- Domestic partner
- Single
- Separated
- Widowed

Exercise Level

- None (No exercise)
- Occasional exercise
- Moderate exercise
- High level exercise

Caffeine

- None
- Occasional
- Moderate
- Heavy

of cups/cans per day? _____

Alcohol

- Do you drink alcohol?
- Yes No

If so, how often?

- Occasionally
- < 3 times a week
- > 3 times a week

How many drinks per week?

Tobacco

Do you use tobacco?

- Yes No

If not currently, did you ever use tobacco? Yes No

- Cigarettes - _____ pks./day
- Chew - _____ /day
- Cigars - _____ /day
- # of years _____
- Or year quit _____

Drugs

Do you currently use recreational or street drugs? Yes No

If yes, list:

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular

- Arm Pain on Exertion
- Chest Pain on Exertion
- Chest Heaviness/Pressure on Exertion
- Irregular Heart Beats (Palpitations)
- Known Heart Murmur
- Light-headed on Standing
- Shortness of Breath When Lying Down
- Shortness of Breath When Walking
- Swelling (edema)

Constitutional

- Exercise Intolerance
- Fatigue
- Fever
- Weight Gain (_____ lbs)
- Weight Loss (_____ lbs)

Eyes

- Dry Eyes
- Irritation
- Vision Change

Date of Last Exam: _____

Ears/Nose/Mouth/Throat

- Bleeding Gums
- Difficulty Hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent Infections
- Frequent Nosebleeds
- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in Ears

Endocrine

- Fatigue
- Increased Thirst/Hunger/Urination

Gastrointestinal

- Abdominal Pain
- Black or Tarry Stool
- Blood in Stool
- Change in Appetite
- Frequent Indigestion
- Hemorrhoids
- Trouble Swallowing
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Difficulty Urinating
- Incomplete Emptying
- Increased Urinary Frequency
- Urinary Loss of Control

Hematologic/Lymphatic

- Easy Bruising/Bleeding
- Swollen Glands

Integumentary (Skin)

- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions
- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal

- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological

- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric

- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in Relationship
- Mania
- Sleep Problems

Respiratory

- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

Please add any other information about your health that you would like your provider to know here:

Patient, Parent, Guardian, or Caregiver Signature

Date

Name:

Chart:

DOB:

Date:

CENTER FOR ADVANCED ORTHOPEDICS AND SPORTS MEDICINE FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Payment of your bill is part of this treatment and care. Your coverage by your health insurance carrier is unique to your policy. It is your responsibility to know and understand what your insurance plan will cover and pay.

We accept payment by cash, check, VISA, MasterCard, American Express and Discover. Care Credit is available and information is available. A \$30.00 fee will be charged for non-sufficient funds.

When you register for the first time at our office you will be asked for some form of picture identification as well as your current insurance cards. We apologize for any inconvenience, but we have to ask for this information to protect you against insurance identify theft.

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, your appointment will be rescheduled.

If you are a patient presenting with back pain, your insurance company may require a separate spine care referral. Currently, Priority Health and Blue Care Network require specific spine care referrals. If you require further information regarding the spine care referral program, please ask to speak with one of our billing specialists.

Co-Payments are due on the day of visit. We are bound by contracts that we have signed with the insurance companies and waiving of any co-pays and/or deductibles is forbidden.

If your physician recommends surgery, you will be escorted to his Surgery Scheduler. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved and complete all pre-certification/authorization if your insurance company requires it. The Surgery Scheduler will request a pre-surgical deposit if you do not have health insurance to cover your surgery charges.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Center for Advanced Orthopedics and Sports Medicine. I authorize Center for Advanced Orthopedics and Sports Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date

Signature

Printed Name

Name:

Chart:

DOB:

Date:

Mykola J. Bartkiw, D.O.
 Michael P. Donahue, D.O.
 Christopher R. Nicholas, D.O.
 John R. Olenyn, M.D.
 Allen R. Prince, D.O.
 Paul J. Siatczynski, M.D.
 Sara Wierzbicki, PA-C



CENTER FOR
Advanced Orthopedics
 AND SPORTS MEDICINE

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 Tel (248) 377-8000
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 www.centerforao.com

**New Patient Consent to the Use and Disclosure of Health Information
 for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, CAO originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* (located in the waiting room) that provides a more complete description of information uses and disclosures. I understand that I have the following rights and responsibilities:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that CAO is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CAO reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should CAO change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

E-PRESCRIPTION CONSENT

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

I agree that Center for Advanced Orthopedics and Sports Medicine, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

At what number can you be reached? _____

May we leave a message on your voice mail/answering machine? Yes No

 Patient's Signature

 Date

Name:

Chart:

DOB:

Date:

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Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescription to mail order

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy, however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

Patient Name:

Date of Birth:

Home Phone:

Work Phone:

Cell Phone:

Please list your drug allergies or select "no known drug allergies":

No known drug allergies

MAIN PHARMACY:

Name (e.g. CVS, Rite-Aid, etc) _____
 Street Name & City _____
 Phone: _____ Fax: _____

ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:

Name (e.g. CVS, Rite-Aid, etc) _____
 Street Name & City _____
 Phone: _____ Fax: _____

Name (e.g. CVS, Rite-Aid, etc) _____
 Street Name & City _____
 Phone: _____ Fax: _____

THIS INFORMATION IS NOT PART OF THE MEDICAL RECORD

Input into system