Name:
Chart: DOB:
Date:

CENTER FOR ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, P.C.

Spine Questionnaire

Please complete this packet. Your careful answers will help us to understand your presenting problem and design the best treatment program for you.

What is the main problem(s) for which you are seeking treatment today?

_____

Have you ever had similar problems before? ☐ YES ☐ NO _____

Did your symptoms start ☐ suddenly ☐ gradually

Please indicate how your present symptoms began?

☐ During an athletic activity ☐ While seated ☐ While bending
☐ As a result of an auto accident ☐ While lifting ☐ While working
☐ Unknown

Please indicate below where your pain/symptom was initially located:

☐ neck ☐ mid back ☐ low back and legs
☐ neck and arms ☐ low back ☐ unknown

Please mark the most appropriate statement:

☐ my symptoms have remained the same since the time of injury
☐ my symptoms are more severe since the time of injury
☐ my symptoms are less severe since the time of injury

How have the symptoms / pain changed?

☐ they are unchanged
☐ increased aggravation in one arm or leg
☐ increased aggravation in both arms or legs ,:
☐ increased aggravation in the back or neck
☐ increased aggravation in both arms / legs and back / neck

Which of the below best describes your pain ratio?

☐ 100% back / neck pain
☐ 75% back / neck pain and 25% leg / arm pain
☐ 50% back /neck pain and 50% leg / arm pain
☐ 25% back / neck pain and 75% leg / arm pain
☐ 100% leg / arm pain

Is your pain (please check one)?

☐ Constant ☐ Intermittent and occurring daily ☐ Intermittent and occurring most days ☐ Infrequent

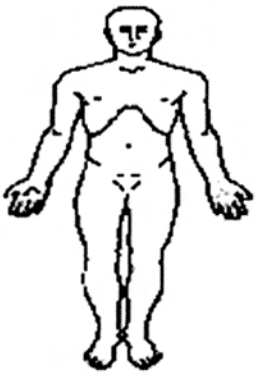
PAIN SEVERITY SCALES

(NO PAIN) (SEVERE PAIN)
0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 (PAIN)

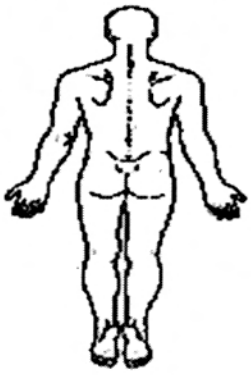
Use **X** to mark current pain and **O** to mark pain over the last month

Name:
Chart: DOB:
Date:

LOCATION – Please mark the location(s) of your pain on the diagrams below



Front



Back

ACTIVITY (check the approximate amount of time you can perform the following activities):

	Unable	15 minutes	30 minutes	45 minutes	1 hour	indefinitely
SIT	☐	☐	☐	☐	☐	☐
STAND	☐	☐	☐	☐	☐	☐
WALK	☐	☐	☐	☐	☐	☐
LIE FLAT	☐	☐	☐	☐	☐	☐

PREVIOUS TREATMENT (check all the treatments you have tried for your pain)

☐ Physical Therapy if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Heat / Ice if yes, how long _____ Improved? ☐ Yes ☐ No
☐ TENS / Ultrasound if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Brace / Collar if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Massage if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Meditation if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Psychotherapy if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Acupuncture if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Chiropractic if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Other _____
☐ Surgery Date/Type of surgery _____
if yes, how long _____ Improved? ☐ Yes ☐ No
☐ Epidural Injections if yes, how long _____ Improved? ☐ Yes ☐ No

DIAGNOSTIC STUDIES

Type	Date	Results
☐ X-rays	_____	_____
☐ MRI	_____	_____
☐ CT	_____	_____
☐ Myelogram	_____	_____
☐ Discogram	_____	_____
☐ EMG / NCS	_____	_____

Name:

DOB:

Date:

Please check all items you feel are applicable to your pain or discomfort:

- ☐ genital numbness
- ☐ bowel accidents / incontinence
- ☐ bladder accidents / incontinence
- ☐ recent infections
- ☐ fever or chills
- ☐ weight loss / gain
- ☐ arm/ leg numbness
- ☐ severe night pain
- ☐ fatigue
- ☐ changes in appetite
- ☐ poor sleep
- ☐ swollen glands
- ☐ headaches
- ☐ eye pain
- ☐ double vision
- ☐ loss of vision
- ☐ sinusitis
- ☐ sore throats
- ☐ hoarse voice
- ☐ difficulty hearing
- ☐ ringing of ears
- ☐ anemia
- ☐ cold hands /feet
- ☐ leg swelling
- ☐ shortness of breath
- ☐ murmur
- ☐ palpitations
- ☐ chest pain
- ☐ pneumonia
- ☐ bronchitis
- ☐ asthma
- ☐ cough
- ☐ productive sputum
- ☐ ulcer
- ☐ indigestion
- ☐ bloating
- ☐ diarrhea
- ☐ nausea
- ☐ abdominal pain
- ☐ constipation
- ☐ blood in stool
- ☐ black stools
- ☐ difficult urination
- ☐ pain w/ urination
- ☐ blood in urine frequent
- ☐ bladder infections
- ☐ arthritis
- ☐ red / swollen joints
- ☐ limited motion
- ☐ osteoporosis
- ☐ dry eyes
- ☐ dry mouth
- ☐ gout
- ☐ muscle aches
- ☐ excess sweating
- ☐ cold intolerance
- ☐ jitteriness
- ☐ thyroid problems
- ☐ menopause
- ☐ painful periods
- ☐ vulvar pain
- ☐ painful intercourse
- ☐ impotence
- ☐ eczema
- ☐ psoriasis
- ☐ hypersensitivity
- ☐ rash
- ☐ dizziness
- ☐ feeling depressed
- ☐ anxiety / nervousness

Have you had any of the following health problems (please check all that apply)?

- ☐ High blood pressure
- ☐ diabetes or high blood sugar
- ☐ kidney disease
- ☐ heart disease
- ☐ sleep apnea
- ☐ liver disease
- ☐ asthma or wheezing
- ☐ seizure or epilepsy
- ☐ bleeding problems
- ☐ cancer; please specify

_____

☐ other; please specify

_____

Please do not write below this space

Physician has reviewed the above acknowledges the findings and enters into chart:

_____ _____

M Donahue, D.O. 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:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Cots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes - Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ 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/HOSPTIAL
1.				
2.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Grandfather (maternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Grandmother (paternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Grandfather (paternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Father	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Mother	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Brother/Sister	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Brother/Sister	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Other: _____	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____

Name:

Chart:

Date:

SOCIAL HISTORY

Occupation _____

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

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

Marital Status
☐ Divorced ☐ Married ☐ Single
☐ Domestic partner ☐ 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

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
AdvancedOrthopedics
AND SPORTS MEDICINE

3100 Cross Creek Parkway #200
Auburn Hills, MI 48326
Tel (248) 377-8000
Fax (248) 377-2929
www.centerforao.com

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 Rochester Knee and Sports Medicine.
I authorize Rochester Knee 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

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

3100 Cross Creek Parkway #200
Auburn Hills, MI 48326
Tel (248) 377-8000
Fax (248) 377-2929
www.centerforao.com

Your Insurance Policy:	Staff Process.....	Patient Responsibility...
MEDICARE	Submit claims on behalf of beneficiary including secondary coverage	Payment of 20% at the time of service. If your deductible has not been met for the year, you are required to pay at the time of service. Any services that are not covered, the beneficiary is responsible at the time of service. If you have regular Medicare and have secondary insurance or medigap coverage: No payment is required at the of service. However, the beneficiary is responsible once a decision from the secondary is made.
MEDICARE HMO'S	Submit claims on patients behalf	All applicable copays, deductibles or co-insurances at the time of service.
HMO & PPO Policies that RKSM is contracted with	Verify eligibility and submit claim.	Copays, co-insurance and /or deductible at the time of service. Call your insurance company and verify benefits.
COMMERICAL INSURANCE	Verify eligibility and submit claim.	Copays, co-insurance and /or deductible at the time of service. Call your insurance company and verify benefits.
WORKERS COMPENSATION	Submit claim and provide necessary documentation to case worker.	Providing an authorization letter from your carrier to be evaluated and treated for the date of service. If we do not have a valid authorization you are responsible for payment in full before services are rendered.
AUTO INSURANCE	Verify that you have an open case. Submit claims to appropriate carrier.	Patient is to provide Health Insurance and Claim information from automobile carrier with claim number, date of injury, address, adjustor name and number.
NO INSURANCE	CARE CREDIT AVAILABLE PLEASE SEE RECEPTIONIST	PAYMENT IN FULL REQUIRED AT THE TIME SERVICES ARE RENDERED. IF SUGERY OR SUBSEQUENT VISITS ARE REQUIRED ADDITIONAL CHARGES WILL MAY APPLY.

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

3100 Cross Creek Parkway #200
Auburn Hills, MI 48326
Tel (248) 377-8000
Fax (248) 377-2929
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 privileges:

- 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:

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
AdvancedOrthopedics
AND SPORTS MEDICINE

3100 Cross Creek Parkway #200
Auburn Hills, MI 48326
Tel (248) 377-8000
Fax (248) 377-2929
www.centerforao.com

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