

Advanced Orthopedic Specialists

Providing state of the art orthopedic care in a friendly environment

2305 Genoa Business Park Dr., Suite 170, Brighton, MI 48114

Tel: 810-299-8550 Fax: 810-844-0837 www.advancedortho.net

Laith Farjo, M.D.
Michael Peters, PA-C

Edward Loniewski, D.O.
Heather Cresmen, PA-C

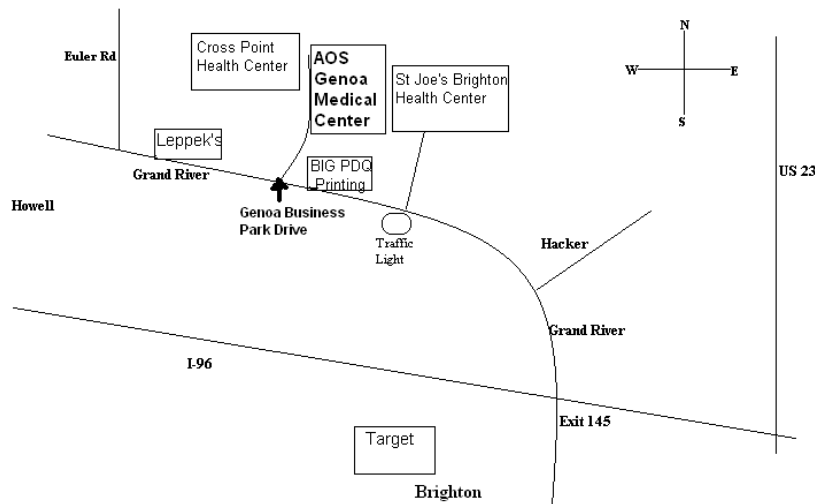
Robert Mihalich, M.D.
Matthew Kenny, PA-C

Your Appointment: _____ **Time:** _____

Please complete the enclosed forms in ink and bring them with you along with your **photo ID (ie: drivers license or state issued ID) and insurance card**. If you cannot fill out these forms prior to your appointment, please arrive 15 minutes early, and we will help you complete them. Please bring a **current medication list**. For your convenience, wheelchairs are available in the lobby.

If you have had testing done outside of the St. Joseph Mercy Health System, please bring the results (report and films) with you to your appointment.

Genoa Medical Center, Suite 170
2305 Genoa Business Park Drive
Brighton, MI 48114



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Patient and Insurance Authorization Information

Date: _____

Patient Name: _____ Date of Birth: _____

First (Legal) Middle Last

Social Security Number: _____ Sex: M F Marital Status: S M D W

Home Phone: _____ Cell/Work Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Race: White Black Asian Hispanic Other Decline **Ethnicity:** Non-Hispanic Hispanic Decline

Is English your primary language? ___ Yes ___ No If no, what is? _____

Employer: _____ Occupation: _____

Emergency Contact: _____

Name

Relationship to Patient

Home Phone: _____ Cell/Work Phone: _____

Policy Holder's Name: _____

First Middle Last

Relationship to Patient

Policy Holder's Employer: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Accidents or Work Injuries

Were you injured at work? Y N In an auto Accident? Y N Is this a liability case? Y N

Date of Injury/Accident: _____ County of Injury: _____

Insurance Company: _____

Adjuster Name: _____ Claim Number: _____

Adjuster Phone: _____ Adjuster Fax: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Is there an attorney involved? Y N If so, Attorney Name: _____

Attorney Phone: _____ Attorney Fax: _____

I attest that the information provided on this form is complete and accurate to the best of my knowledge. I hereby authorize Advanced Orthopedic Specialists to furnish any medical information necessary to process my insurance claim(s) for my treatment acquired in the course of the examination or hospitalization. I authorize payment of medical and/or surgical benefits to Advanced Orthopedic Specialists. I understand that the provider's charge may exceed the insurance allowed amount and payment. I will be responsible for any and all balances such as co-insurance, co-payments, and deductibles.

Signature of Patient/Legal Guardian

Date

Print Name

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Date: _____

PHYSICIAN WHO REFERRED YOU TO OUR OFFICE: _____

Patient Name: _____
First (Legal) Middle Last

What are you seeing the doctor for today? _____

Which side is involved? Right Left Are you : Right Left Handed?

When did the symptoms begin? Date: _____ or 1-2, 3-4, 4-5 or over 5 Days, Weeks, Months, Years

How did this occur? _____

Have you been treated by anyone at anytime for this problem? Yes _____ No _____

If Yes, by whom and where were you treated: _____

Please circle any studies you have had in the past for this problem? : MRI CAT scan X-rays Bone Scan Ultrasound Other: _____

If you have ever had a serious injury to this area, please list the date and type: _____

If you have ever had surgery to this area before, please list the procedure and date: _____

Please circle any treatments you are currently using or have been prescribed in the past: Physical Therapy Injections Bracing/Orthotics Medications: _____

How would you describe your symptoms? Dull Sharp Burning Other: _____

What increases your pain or symptoms? Activity/Exercise Walking Lifting Other: _____

What decreases your pain or symptoms? Rest Ice Heat Medication Bracing Other: _____

Have you been tested for osteoporosis? Yes _____ No _____

FAMILY HISTORY:

(These questions apply to your mother, father, brother, sister, or child)

			Please specify:
Family history of arthritis?	Y	N	
Family history of bone disease?	Y	N	
History of anesthetic problems ?	Y	N	
Blood Clots	Y	N	

Office Use only: Location: Ant post med lat radiates: _____

Instability: Yes No

Tx: MRI INJ PT SURG REFER: _____ TESTS: _____

BRACE MEDS F/U: 1 2 3 4 6 Wk MO Yr PRN

egl 07/08

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PHYSICIAN/PHARMACY CONTACT FORM

To ensure that we keep in contact with the appropriate health care providers, we request that you complete this form. If you do not know the entire address, inform us and we can help. If you change physicians and want us to keep your new physician updated on your progress, please provide us with their information.

Patient Legal Name: _____ **Date:** _____

Primary Care Physician: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Internist: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Specialists: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Pharmacy Name: _____

Address: _____

City: _____ Phone: _____



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Name: _____ Date of Birth: _____ Age: _____

The name I would like to be called is: _____ Height: _____ Weight: _____

Indicate the one person you would like your medical information released to: _____

Health History	Yes	No	Health History	Yes	No	Health History	Yes	No
Chronic Cough or Lung Problems			Heartburn/GERD/Acid Reflux/Stomach Ulcer			Stroke/ TIA /Paralysis		
Shortness of breath after going up flight of stairs			Epilepsy/Seizures- Date of Last seizure:			Lupus		
Recent cold, bronchitis or pneumonia			Chronic Back Problems			Scleroderma		
History of Asthma or Wheezing			Excess Bleeding from Surgery or Bleeding Disorders			Sarcoidosis		
Sleep Apnea			Circulation Problems/Blood Clots			Could you be pregnant?		
**If yes, do you have a CPAP Machine			History of Anemia			Last Menstrual period-Date:		
High Blood Pressure- If yes, how many years?			Diabetes, since:			Dentures/Bridges/Caps		
Chest Discomfort/Tightness with exertion			Liver Disease/Jaundice/Hepatitis			Recreational Drugs		
Heart Attack-Date:			Kidney Disorder			Alcoholic Drinks per week		
Heart Failure-Date:			Myasthenia Gravis			Years smoked ____ packs/day ____		
Heart Murmur			Irregular Heart Beat-Date:			Date stopped smoking:		
Are there any personal or religious reasons you would refuse blood transfusions?			Thyroid Disease					
An exam by a cardiologist? (heart doctor)			If yes, Dr's name?					
Heart Catheterization			If yes, where?					
Exercise Stress Test			If yes, where?					
Ultrasound of Heart (Echocardiogram)			If yes, where?					
Pacemaker/ICD (Implantable Cable Defibrillator)			If yes, where?					
Have you had any serious problems with anesthesia?			If so, what happened?					
Is there any family history of problems with anesthesia?								

Comments _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Advanced Orthopedic Specialists to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

Advanced Orthopedic Specialists' Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Advanced Orthopedic Specialists reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Orthopedic Specialists Privacy Officer at 2305 Genoa Business Park Drive, Suite 170, Brighton, Michigan 48114.

With this consent, Advanced Orthopedic Specialists may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. This includes appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory or other test results.

With this consent, Advanced Orthopedic Specialists may mail to my home or other alternative location, any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that Advanced Orthopedic Specialists 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 Advanced Orthopedic Specialists' 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 in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Orthopedic Specialists may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Printed Name of patient or Legal Guardian

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