PATIENT NAME: _____ **DATE OF BIRTH:** _____

Please check yes or no to all of the following questions:

Head: do you have problems with:
____yes ____no headaches/migraines?
Eyes:____yes ____no do you wear glasses/contacts?
Ears/nose/throat: do you have problems with:
____yes ____no ringing in your ears?
____yes ____no do you wear hearing aids?
Respiratory: do you have problems with:
____yes ____no COPD/emphysema/asthma?
Cardiac: do you have problems with:
____yes ____no heart murmur?
____yes ____no angina/chest pain?
____yes ____no congestive heart failure?
____yes ____no hypertension?
Gastro/Intestinal: do you have a problem with:
____yes ____no heartburn?
Genital/Urinary: do you have a problem with:
____yes ____no difficulty holding your urine?
____yes ____no prostate problems?

Neuro: do you have a problem with:
____yes ____no have you had a stroke?
____yes ____no epilepsy?
Psychiatric: do you have a problem with:
____yes ____no depression?
____yes ____no anxiety?
____yes ____no dementia/Alzheimer's?
____yes ____no ADD/ADHD
Endocrine: do you have problems with:
____yes ____no diabetes?
Hematologic/Lymphatic: do you have problems with:
____yes ____no hepatitis?
____yes ____no HIV?
____yes ____no anemia?
Allergies: ____ penicillin? _____ sulfa? _____latex?
Other Allergies:_____
_____
_____

Social History: Where are you employed? _____

What are your job duties? _____

HEIGHT: _____**WEIGHT:** _____

Family History:

Siblings? ___yes ___no Health problems _____

Father/Mother alive? ___yes ___no Health problems _____

Children:___ yes ___no Health problems _____

Do you smoke? _____ Have you ever smoked? _____ History of substance abuse?_____

Do you use alcohol? ___daily ___occasionally ___never

Please list all past Surgeries:

_____
_____
_____

Please list all medications you are taking, dosage, and how often taking them:

_____
_____
_____
_____

Allegan Orthopedic & Sports Medicine Center
551 Linn Street – Suite 220
Allegan, MI 49010

Telephone (269) 673-5571
Fax (269) 673-1654

Patient Name _____ Today's Date_____
FIRST M LAST

Patient Address _____
CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____
Circle One

Birth Date _____ Social Security # _____ Are you: Single Married Widowed Divorced

Employer _____Email Address _____

If patient is a minor: Parent or Guardian Name(s) _____

Who is your primary care (family) physician? _____
NAME PHONE NUMBER

Who asked you to be seen today? Name and Phone Number – Please Circle One:
Primary Care Physician _____ Other Physician _____
Emergency Room Physician _____ No One/Self _____

Please note that if you do not provide the correct insurance information, it may be possible that you will be responsible for all charges that are incurred during your visit and treatment here. Correct insurance information is very important as we use this information to obtain important authorizations for your treatment and care here. If we are unable to get authorization for your treatment here due to the lack of correct insurance information, you may be responsible for complete charges.

Please sign below stating that you understand this & will provide correct information.

X_____

Problem/Injury: _____

Date of injury _____Current problem is a result of a: Check all that apply:
_____car accident _____work accident _____neither

How did the problem/injury occur? _____

Were X-Rays taken? _____ Date of X-rays: _____ If yes, where? _____

MRI: Date & Place _____ CT: Date & Place _____

FOR OFFICE USE ONLY:
REVIEWED BY: _____ DATE: _____

PRIVACY RIGHTS

We appreciate the trust that you have placed in us, and one of the ways that we will protect that trust is by respecting the privacy of all our patients. We are required by federal and state law to maintain the privacy of your health information. Federal and state laws allow us to use your health information for treatment, payment and for other limited uses. We cannot use or disclose your health information for any reason not allowed by law unless you give us written permission.

In general the privacy law gives you the right to request a restriction on the use and disclosure of your Protected Health Information (PHI). The law does not allow us to speak to a member of your family, another relative, or a close friend who may be involved in your care unless you request in writing that we do so. A complete description of our privacy notice is on display in the reception room, on our website of www.alleganorthopedics.com or available from our receptionist.

I authorize Allegan Orthopedics, P.C. to disclose Protected Health Information for appointment or other healthcare purposes to the following *FAMILY MEMBERS*:

NAME	HOME PHONE NUMBER	OTHER PHONE NUMBER	RELATIONSHIP
NAME	HOME PHONE NUMBER	OTHER PHONE NUMBER	RELATIONSHIP

I acknowledge that I have reviewed and understand the Allegan Orthopedics Privacy Notice.

X_____

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE DATE

Consent for Medical Treatment: I authorize Allegan Orthopedics, P.C. physicians and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments. I further authorize order of x-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

X_____

SIGNATURE DATE

INSURANCE ASSIGNMENTS

I. MEDICARE (SIGN THIS SECTION ONLY IF YOU ARE COVERED BY MEDICARE)

I authorize any holder of medical or other information about to release to the Social Security Administration & Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to Allegan Orthopedics, P.C. which accepts assignment below.

SIGNATURE

II. OTHER INSURANCE (ALL PATIENTS MUST SIGN THIS SECTION)

I authorize and assign payment directly to Allegan Orthopedics for the care, supplies and imaging studies involved in my treatment of my child's treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance, INCLUDING co-payments and deductibles.

FOR WORKER'S COMPENSATION PATIENTS:

I hereby understand that if my services are rejected by workers compensation to be non-related or in dispute of a work-related injury, that I am financially responsible for these charges.

FOR MANAGED CARE PATIENTS:

I understand if my service is not a covered benefit and that without an authorization/referral form from my HMO/IPA/PPO. I will be financially responsible for charges I incur.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN

PRINT NAME DATE