Oakland Orthopedic Partners, P.C., *office of*
Bruce T. Henderson
44555 Woodward Ave., Suite 407. Pontiac, MI 48341
248-334-0524
www.oaklandorthopedic.com

Patient Registration Form

Please print clearly and complete all items.

Date _____

First and Last Name _____

Email Address _____ Middle Initial _____

Patient Date of Birth _____ Age _____ Patient SS # _____ - _____ - _____

Marital Status ☑ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Female ☑ Male

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell / Work Phone _____

Smoker? ☐ Yes ☐ No Drug Allergies _____

Other Medical Problems _____

_____

_____

Emergency Contact Name _____

Emergency Contact Phone _____

Family Physician _____

Physician Phone _____ Physician Fax _____

Who referred you to our office? _____

Patient Insurance Information
(Continued)

Our office participates in the following insurances:

- Aetna *
- Alliance Health & Life
- Alliance Medicare Pro
- Beech Street
- Blue Cross Blue Shield (all)
- Blue Care Network HMO **
- BCN Advantage (Medicare)
- Cigna / Great West *
- Cofinity / PPOM
- HAP HMO ****
- HAP PPO
- HAP Senior Plus ****
- Health Plus HMO **
- Health Plus PPO
- Humana Medicare
- McLaren PPO
- Medicare
- Medicare Advantage
- Medicare Plus Blue
- Molina - Medicare Only
- Priority Health PPO/HMO
- PHCS
- Tricare (PPO) & Tricare For Life
- UHC / Great Lakes HMO (OPNS) ***
- United Healthcare *
- Workers Comp & Auto *****

* There are several different Aetna, Cigna, and United Healthcare plans; We always advise patients to call their insurance and verify that we are participating in the certain plan you have.

** This insurance requires a referral. The patient must obtain a referral prior to their appointment. The patient will not be seen without a referral.

*** Must obtain a referral through OPNS

**** HAP has an open network. You should not need a referral unless your PCP is out of any of the following networks: Access, DMC, Henry Ford Medical Group and Genesys, or if you have HAP Senior Plus. However, we always advise patients to check with your PCP to find out if you will need a referral to see us.

***** Must have an open claim letter from the Workers Comp / Auto Insurange Company. If you have any insurance other than what's listed above, we will submit your claim to your insurance carrier. However, if your insurance does not pay, you are responsible for the charges. All copays are to be paid at the time of service. Patients with no insurance, or involved in, or will be involved in any litigation are expected to pay for services or make arrangements to make payments.

If you have any questions about these policies, please ask us to explain.

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. Failing to know your coverage could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, and not the insurance company and the doctor.

By signing below, I authorize Oakland Orthopedic Partners, P.C. to submit claims to my insurance carrier(s) for all services rendered. I direct my insurance carrier(s) to issue all payments dtirectly to Oakland Orthopedic Partners, P.C.

I understand that I am responsible for the balance on my account regardless of my insurance status. I understand that if my insurance company denies, rejects, or fails to make payment to Oakland Orthopedic Partners, P.C., I will be responsible for any outstanding balance. I understand that if I am the parent requesting treatment for a minor child, that I am responsible for all services rendered. I have completed all of the above information and certify this to be true and correct to the best of my knowledge.

I authorize Oakland Orthopedic Partners, P.C. to furnish my insurance carrier(s) with any and all information that they may request - relative to all of the treatment rendered by Oakland Orthopedic Partners, P.C.

Assignments and Authorizations

Please sign and bring this form to the receptionist with insurance card.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

Responsible Party Signature (if patient is a minor) _____

Patient Insurance Information

Dear Patient, due to frequent changes in individual insurance policies, we strongly recommend that you contact your insurance carrier to confirm that it will cover the services you receive at our office.

Type of Insurance _____

Insured Name _____

Insured Employer _____

Insured Employer Address _____

Employer Phone _____

Workers Compensation Claim (leave blank if not applicable)

*** If you are filing a Workers Compensation Claim, we require a letter of authorization or a written statement detailing your coverage from your employer.

Date of Injury _____ Claim # _____

W/C Carrier _____

Address of Carrier _____

Auto Insurance Claim (leave blank if not applicable)

** If you are filing an Auto Insurance Claim, we require a letter of authorization or a written statement detailing your coverage from your insurance carrier.

Date of Injury _____ Claim # _____

Insurance Carrier _____

Address of Carrier _____

Do you intend to apply for any of the following programs? Please check Yes or No for each.

	Already Enrolled		Applied For		Intend to Apply	
Social Security	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Disability	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Workers Comp	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Patient Questionnaire

Initial Evaluation

Please complete the following questionnaire before you see the doctor. Please answer the question in as much detail as possible.

The information that you provide will help your doctor to more accurately understand your medical problem(s) and to develop an appropriate plan of treatment for your care. Thank you!

Occupation _____

What are you seeing the doctor for?

_____

_____

_____

When did your problem first begin or when did the injury first occur?

_____

_____

Is the injury work related? ☐ Yes ☐ No

Have you seen a doctor in the past for this problem/injury? ☐ Yes ☐ No

If yes, who did you see and when?

_____

_____

Please explain how the injury occurred.

_____

_____

What previous treatment have you had? Medication, therapy, surgery, etc.?

_____

_____

Past Medical History

Check any item below to which you are allergic:

- ☐ No known allergies
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Morphine
- ☐ Erythromycin
- ☐ Codeine
- ☐ Iodine/Betadine
- ☐ Radiographic Dyes
- ☐ Adhesive Tape
- ☐ Latex
- ☐ Other (specify)

_____

_____

Check any of the medical problems listed below that you have now:

- ☐ I have no known medical problems
- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular Disease
- ☐ Adult Onset Diabetes
- ☐ Childhood Onset Diabetes
- ☐ A Past Heart Attack
- ☐ Asthma
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Cancer
- ☐ Osteomyelitis
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Seizure Disorders
- ☐ Thyroid Disease
- ☐ Emphysema
- ☐ COPD/Lung Problem
- ☐ Immune Disorder
- ☐ Overweight
- ☐ Other (specify)

_____

_____

_____

How much alcohol do you consume?

- ☐ Non-drinker
- ☐ Recovering alcoholic
- ☐ Drink occasionally
- ☐ Drink on weekends only
- ☐ 1-2 Drinks per day
- ☐ 2-3 Drinks per day
- ☐ 3-4 Drinks per day
- ☐ More than 6 drinks per day

Have you ever smoked cigarettes?

- ☐ No, I have never smoked.
- ☐ I do not smoke now, however, I used to smoke _____ years ago.
- ☐ I am a smoker at this time, I have smoked for _____ years.
- ☐ I smoke ☐ 1 ☐ 2 ☐ 3 packs of cigarettes per day.

Past Medical History
(continued)

Do you now or have you ever used illicit drugs?

- ☐ No I have never used illicit drugs
- ☐ I am a recreational user of marijuana
- ☐ I have used Heroin / Cocaine
- ☐ Other (specify) _____

Has any member of your immediate family ever had any of the following illnesses?

- ☐ Cancer
- ☐ Leukemia
- ☐ Stroke
- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Hypothyroidism
- ☐ Colitis
- ☐ Bleeding Tendency
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Seizure Disorders
- ☐ Other (specify)

_____

_____

_____

Check any of the surgeries listed below that you have had. Indicate the approximate year of surgery.

- ☐ No previous surgeries _____
- ☐ Appendectomy _____
- ☐ Cataract Surgery _____
- ☐ By-Pass Open Heart _____
- ☐ Gall Bladder _____
- ☐ Hernia Repair _____
- ☐ Hysterectomy _____
- ☐ Lumbar Laminectomy _____
- ☐ Mastectomy _____
- ☐ Tonsillectomy _____
- ☐ Prostate Surgery _____
- ☐ Other (specify)

_____

_____

Have you previously broken any bones? _____

Have you ever had any blood transfusions? ☐ Yes ☐ No Year _____

Please list any medications that you are currently taking, including both prescription and non-prescription.

Medications	Dose	# Items Per Day

Past Medical History
(continued)

Please tell us about your health in general. Check the following symptoms you experience and provide comments if applicable.

Symptoms	Comments
☐ Chest Pain	_____
☐ Dizziness	_____
☐ Productive Cough	_____
☐ Difficulty Breathing	_____
☐ Irregular Heartbeat	_____
☐ Swelling in Legs	_____
☐ Lack of Appetite	_____
☐ Increase in Appetite	_____
☐ Nausea	_____
☐ Vomiting	_____
☐ Constipation	_____
☐ Abdominal Cramping	_____
☐ Varicose Veins	_____
☐ Unusual Bruising	_____
☐ Unusual Bleeding	_____
☐ Frequent Nose Bleeds	_____
☐ Joint Pain/Stiffness	_____
☐ Muscle Pain/Cramps	_____
☐ Difficulty Seeing	_____
☐ Difficulty Hearing	_____
☐ Difficulty Swallowing	_____
☐ Difficulty Sleeping	_____

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Limited Patient Authorization for Disclosure of Protected Health Information

Please print clearly and complete all items. Form must be signed and dated each year.

Patient Last Name _____

Patient First Name _____ Middle Initial _____

Patient Date of Birth _____ Age _____ Patient SS # _____ - _____ - _____

I authorize Oakland Orthopedic Partners, P.C. to disclose or provide protected health information about me, as states in this authorization.

Who will be authorized to receive information (family, friends, others):

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above.

Entire patient record, including but not limited to (check items to disclose)

- ☐ office notes
- ☐ x-rays, hospital, nursing home, home health, hospice, & other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ financial history report (previous 3 years only)

Limited Patient Authorization for Disclosure of Protected Health Information

(continued)

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

☐ Patient request

☐ Patient transferring to our care

☐ Patient referred to us for treatment of _____

☐ Other (please specify) _____

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You must have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year) _____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form. I have the right to receive a copy of signed authorization upon request.

Patient Signature _____ Date _____

(The section below is for office use only)

Documentation of Failure to Obtain Signed Acknowledgement

Oakland Orthopedic Partners, P.C. presented this Acknowledgement of Receipt of Notice of Privacy Practices to patient (named below). The patient refused a signature when requested (date below).

Patient Name _____

Administrative Signature _____ Date _____

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Prescription Transmission Form

Dear Patient, for your convenience and safety, we offer a computerized prescription program that will improve both the accuracy and convenience of prescribing medications.

What electronic transmission means to you:

• Prescriptions will be sent directly to the main pharmacy, reducing your wait time at the pharmacy
• Faster transmission of your prescription to mail order pharmacies

To implement this program, we need to collect some information from you:

• Your main pharmacy
• Additional pharmacies to be used as an alternative
• Mail order benefit program if applicable

We understand that you may not have the 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's Name _____

Patient Address _____

Main pharmacy

Name (i.e. CVS, Rite Aid, etc.) _____

Street Name & City _____

Phone _____ Fax _____

Additional pharmacies you would like to keep on file

Name (i.e. CVS, Rite Aid, etc.) _____

Street Name & City _____

Phone _____ Fax _____

Name (i.e. CVS, Rite Aid, etc.) _____

Street Name & City _____

Phone _____ Fax _____

Please list your drug allergies _____

_____