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3535 W. 13 Mile Rd. Suite 205
Royal Oak, Michigan 48073

Phone: 248-551-8180
Fax: 248-551-8181

Thank you for choosing our office. PLEASE COMPLETE PAPERWORK (FRONT AND BACK) AND BRING WITH YOU ON THE DAY OF YOUR APPOINTMENT. All information will be strictly confidential.

Patient's Name:_____ Today's Date:_____

Birth Date:_____Age_____Male_____Female_____

Marital Status: Single_____Married_____Widowed_____Divorced_____

Patient's Address:_____

_____

City State Zip

Home Phone Number:(_____)_____Cell:(_____)_____

Business Phone Number:(_____)_____

Patient's Social Security_____E-Mail_____

Race: African American_____American Indian_____Asian_____Caucasian_____

Native Hawaiian/Pacific Islander_____Other_____

Ethnicity:_____Preferred Language:_____

Do you need an interpreter: Y N

Name of Spouse:_____Birth Date:_____

PATIENT'S Occupation:_____

Name of Employer:_____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. FURTHERMORE, I AUTHORIZE THIS OFFICE TO RELATE OUR EVALUATION TO OTHER PHYSICIANS PROVIDING CARE TO ME THAT WILL ENHANCE CONTINUITY OF CARE.

Patient or Guardian Signature_____

Patient Name:_____Date_____

Past Medical History **(please circle response for each question)**

Diabetes Y or N	If yes, please answer questions below Insulin Y or N Neuropathy Y or N Retinopathy Y or N Diabetic pills Y or N Nephropathy Y or N		
High blood pressure	Y or N	Hepatitis	Y or N
High cholesterol	Y or N	Liver disease	Y or N
Cancer (list type)	Y or N	Headache (list type)	Y or N
High triglycerides	Y or N	Asthma	Y or N
Obstructive sleep apnea Snoring C.Pap/BiPap	Y or N	Psychiatric hospitalizations	Y or N
Joint pain (circle areas) Low back, hip, knee, ankle Foot, hands, shoulder, other.	Y or N	Bowel disease (colitis, irritable Bowel, etc.)	Y or N
Depression	Y or N	Kidney disease	Y or N
Heartburn/reflux	Y or N	Kidney stones	Y or N
Hiatal hernia	Y or N	Kidney failure on dialysis?	Y or N Y or N
Heart disease	Y or N	Skin disorder	Y or N
Heart attack	Y or N	Osteoporosis	Y or N
Heart failure	Y or N	Stroke	Y or N
Irregular heart rate	Y or N	Ulcers	Y or N
Chest pain or angina	Y or N	TB	Y or N
Bladder incontinence	Y or N	Hypoglycemia	Y or N
Leg/ankle swelling	Y or N	Varicose veins	Y or N
Blood clot or phlebitis (DVT)	Y or N	Gout	Y or N
Pulmonary embolus (blood clot In lung)	Y or N	Rheumatic fever	Y or N
Gallstones or gallbladder problems	Y or N	Blood in stool	Y or N
Shortness of breath with activity	Y or N	Crohn's disease	Y or N
Anemia	Y or N	Ulcerative colitis	Y or N
Seizures	Y or N	Obesity	Y or N
Bleeding problem	Y or N	Glaucoma	Y or N
COPD/emphysema	Y or N	Home oxygen	Y or N
Diarrhea	Y or N	Constipation	Y or N
Anesthetic reaction	Y or N	Difficult to place breathing tube	Y or N

Do you have any religious, culture or spiritual beliefs that would prevent you from receiving blood? Y or N

Please list any other medical conditions not listed above_____

Patient Name:_____Date_____

Previous Surgical Operations/Anesthetics

With respect to each and every operation which you have undergone, please provide the following information.

Operation	Date	Problems/Complications (if any)

Past Non-Surgical Hospitalizations

Please list all previous major non-surgical hospitalizations.

Problem	Date	Location/Hospital

PHARMACY NAME:_____

Address:_____

_____

Phone Number:_____Fax Number:_____

Patient Name:_____Date_____

Cardiac Procedure History:

Have you had a EKG?
If yes, when?_____

Have you had a STRESS TEST?
If yes, when?_____

have you had a CARDIAC CATHETERIZATION?
If yes, when?_____

Medication History

Please list current medications, including dosage and frequency.

Prescription Drugs

Name	Dose	Frequency

Over-the-Counter Medications/Vitamins

Patient Name:_____Date_____

Food Allergies

Have you ever had a reaction to any of the following:			If yes, please explain:
Milk/Dairy Products	Y	N	_____
Eggs	Y	N	_____
Shellfish	Y	N	_____

Medication Allergies

Are you allergic to any medications? ⚉ Yes ⚉ No

If so, please provide the following information concerning each and every medication to which you are allergic.

Name of Medication	Type of Reaction

Are you allergic to Latex? ⚉ Yes ⚉ No
Are you allergic to Iodine Dye? ⚉ Yes ⚉ No

Patient Name:_____Date_____

Emergency Contact Information:

Name:_____Relationship:_____

Home Phone:_____Cell Phone:_____

Name:_____Relationship:_____

Home Phone:_____Cell Phone:_____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name:	
Address (if known)	
Telephone Number (if known)	
Hospital doctor is affiliated with:	

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name:	
Address (if known)	

ENDOCRINOLOGIST (if applies)

Endocrinologist's Name:	
Address (if known)	

Please list all other medical doctors with which you are currently being treated

PHYSICIAN NAME:	SPECIALTY:

Patient Name:_____Date:_____

Family History: Has anyone in your family had any of the following? **If YES, please state which family member.**

			relationship
High blood pressure	Y	N	_____
High cholesterol	Y	N	_____
Heart disease	Y	N	_____
Stroke	Y	N	_____
Diabetes	Y	N	_____

Cancer (list types)

_____

_____

Bleeding disorders	Y	N	_____
Blood clots	Y	N	_____

WOMEN:

Are you currently pregnant? Y or N

Number of pregnancies:_____ Number of live births:_____

Patient Name:_____Date_____

Alcohol, Tobacco and Drug Consumption

ALCOHOL:

How often do you drink alcohol?
A: never B: 1 time per month or less C: 2-4 times a month D: 2-3 times a week
E: 4 or more times a week Daily (at least once per day)

If you indicated above that you drink "daily", please state:
How many times per day?_____
What type of alcoholic drink?_____

How often do you have six or more drinks on one occasion?
A: never B: less than monthly C: monthly D: weekly E: daily or almost daily

Have you ever participated in an alcohol or drug rehabilitation program?
Yes No

TOBACCO:

Do you presently smoke tobacco? Yes No
If yes:
How many packs per day?_____

Have you ever smoked tobacco? Yes No
If yes:
How many packs per day?_____
For how many years?_____
When did you quit?_____

Do you presently use smokeless tobacco? Yes No
If yes: Snuff Chew

Have you ever used smokeless tobacco? Yes No
If yes:
When did you quit?_____

DRUG CONSUMPTION:

Do you currently use illicit drugs? Yes No

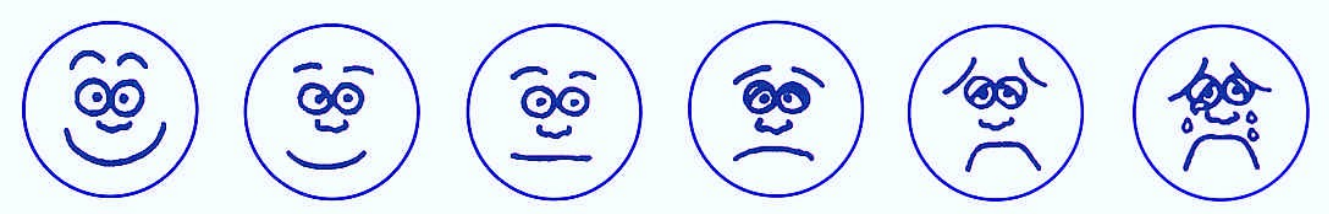
If yes, what type of drugs do you currently use?_____

How often do you use illicit drugs?_____

Have you ever used illicit drugs in the past? Yes No

Patient Name:_____Date_____

PAIN ASSESSMENT (please circle) <u>regarding the reason for your visit with our office.</u>



No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst
0	2	4	6	8	10

Location of pain:_____

If no pain is indicated, it will be marked zero in your medical record.

HISTORY OF FALLING:

Have you had 2 or more falls in the past year or a fall with injury in the past year?

Y N

If no fall is indicated, it will be marked as no falls in your medical record.

ADVANCED DIRECTIVE/LIVING WILL:

Please circle Yes or No: Do you have a Advanced Directive/Living Will:

Y or N

If **Yes**, please bring a copy with you on the day of your appointment so that we can scan it into your Beaumont Health System medical record. It will be returned at checkout.
Thank you.

PATIENT NAME:_____ DATE:_____

PLEASE CHECK ALL CURRENT SYMPTOMS.

REVIEW OF SYSTEMS SHEET

CONSTITUTIONAL
- Fever_____
- Chills _____
- Weight Loss_____
- Fatigue_____
- Sweats_____
- Weakness_____

SKIN
- Rash_____
- Itching_____
- Jaundice_____

HENT:
- Headaches_____
- Hearing loss_____
- Ringing in ears_____
- Ear pain_____
- Nosebleeds_____
- Congestion_____
- Sore throat_____

EYES:
- Blurred vision_____
- Double vision_____
- Photophobia_____

MUSCULOSKELETAL
- Myalgias_____
- Neck pain_____
- Back pain_____
- Joint pain_____
- Falls_____

NEUROLOGICAL
- Dizziness_____
- Tingling_____
- Tremor_____
- Sensory change_____
- Speech change_____
- Focal weakness_____
- Seizures_____

CARDIOVASCULAR
- Chest pain_____
- Palpitations_____
- Shortness of breath_____
- Claudication_____
- Leg swelling_____

RESPIRATORY:
- Cough_____
- Shortness of breath_____
- Wheezing_____

GASTROINTESTINAL
- Heartburn_____
- Nausea_____
- Vomiting_____
- Abdominal pain_____
- Diarrhea_____
- Constipation_____
- Blood in stool_____

GENITOURINARY
- Pain or burning_____
- Urgency_____
- Frequency_____
- Blood in urine_____

PSYCHIATRIC
- Depression_____
- Suicidal ideas_____
- Substance abuse_____
- Hallucinations_____
- Nervous/anxious_____
- Insomnia_____
- Memory loss_____

ENDOCRINE
- Appetite changes_____
- Cold intolerance_____
- Increased thirst_____
- Increased urination_____
- Hair changes_____

HEMATOLOGY
- Easy bruising_____
- Enlarged lymph nodes_____
- Prolonged bleeding_____

COMPLETION OF THIS FORM ALLOWS US TO SPEAK WITH PEOPLE LISTED IN #2.

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION WAIVER OF PRIVACY

The undersigned,_____

whose address is_____ states:

1. **Authorization.** You are authorized to do the following:

   a. Disclose any and all information regarding my past and current medical treatment and care;

   b. Provide copies of all documents and records in your possession regarding my medical condition and treatment, at any time, including medical history and findings, consultations, prescriptions, treatments, x-rays, radiology reports, special consultation reports, diagnosis and prognosis, copies of all hospital, medical and billing records.

2. **Provide Information To.** The information identified in this document may be released, provided to, or discussed with any of the following persons: _____

   _____

3. **When to Provide Information.** You are authorized to provide the information identified in this document at the request of the individual or individuals identified in paragraph 2 above.

4. **Expiration.** This Authorization contains no expiration date.

5. **Authority to Revoke.** The undersigned reserves the right to revoke this authorization. In order to revoke this authorization, the notification must be written, signed by the undersigned, and dated. The revocation will then become effective upon delivery to you.

6. **Redisclosure.** I understand that the information disclosed by reason of this document may be subject to re-disclosure by the recipient and therefore may no longer be protected under state or federal law.

7. **Photostatic Copies.** A photostatic copy of this Authorization shall be considered as effective and valid as the original.

8. **Voluntary Action.** I understand that I am not required to sign this document and I am signing this document voluntarily.

9. **Privacy Waiver.** With regard to the disclosure of information authorized in this document, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation that might otherwise prevent any health care provider from providing access to my medical records under this document, and I hold harmless from any claim of liability under such act, rule or regulation, any medical provider who provides access to my medical information and records under this document.

10. **Durable Power**. This power of attorney shall not be affected by my disability. The authority of my agent shall be exercisable notwithstanding my later disability or incapacity or later uncertainty as to whether I am alive.

Dated: _____

_____
Signature

_____
Print Name

PREPARED BY FERGUSON & WIDMAYER, P.C.
538 North Division
Ann Arbor, Michigan 48104
734-662-0222

PLEASE COMPLETE NAME, ADDRESS, #2, DATE AND SIGN.

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting [name or title of Privacy Officer].

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature	Date Time
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update:___/___/___

PLEASE SIGN AND DATE
PLEASE OBTAIN A PRIVACY POLICY PACKET IN ROYAL OAK SURGICAL ASSOCIATES LOBBY.

Royal Oak Surgical Associates, P.C.
3535 W. 13 Mile Rd.
Suite 205
Royal Oak, Michigan 48073
Phone: 248-551-8180
Fax: 248-551-8181

Patient Financial Policy

Royal Oak Surgical Associates PC, have implemented the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and treatment to you. Your understanding of your financial responsibilities is an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, payment is due at the time of service for any copays, coinsurance, deductibles or previous balances. For your convenience we accept Cash, Check, Visa, Mastercard, Discover and American Express.

Your Insurance

We have made prior arrangements with many insurance plans to accept an assignment of benefits. Your healthcare policy contract is between you and your insurance company which you or your employer has agreed upon. You may be required to pay for deductibles, copays, co-insurance, or cost share amounts.

If you are enrolled in a HMO and require a referral, you are responsible for providing that information. Failure to provide proper authorization will require the patient to reschedule their appointment or pay for services rendered.

In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____
Printed Name of the Patient

_____ _____
Signature of Patient or Responsible Party if a Minor Date