Advanced Orthopedic Specialists, P.C.
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. **Matthew Caid, D.O.** **Robert Mihalich, M.D.**
Chris Stuart, PA-C Matthew Schymick PA-C **Thomas Sheppard, PA-C** **Jacob Thompson, PA-C**

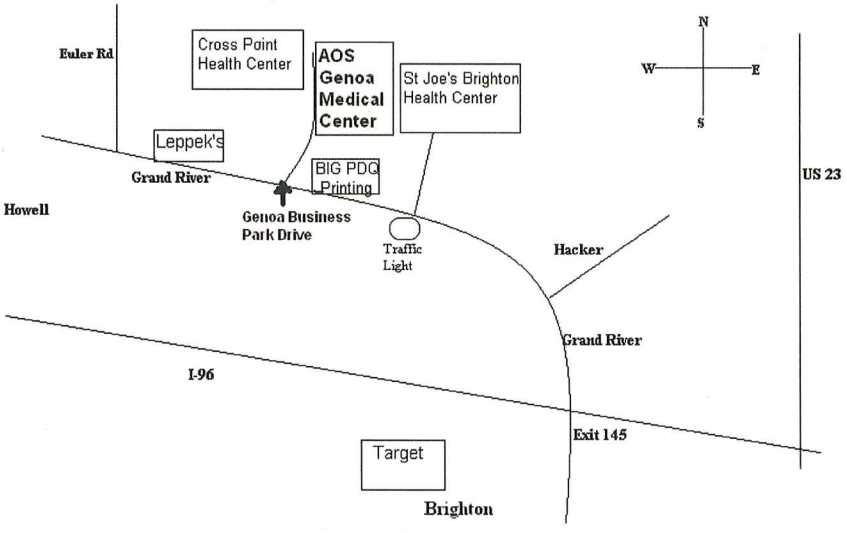
Your Appointment: _____ Time: _____

Please complete the enclosed forms in ink and bring them with you along with your **photo ID (i.e.: driver's 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.

Brighton Office

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 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

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Date: _____

PHYSICIAN WHO REFFERED 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 _____ If yes, when? _____

Month/Year

If yes, were you diagnosed with osteopenia or osteoporosis? Yes _____ No_____

FAMILY HISTORY:

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

			If yes, please specify which family member:
Family history of arthritis?	Y	N	
Family history of bone disease?	Y	N	
History of anesthetic problems ?	Y	N	
Blood Clots	Y	N	

7/08, clg 9/13. 5/23

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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.

Date:_____

Patient Legal Name: _____ **DOB:**_____

Primary Care Physician/ Internist: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Cardiologist: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Specialists: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Specialists: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Pharmacy Name: _____

Address: _____

City: _____Phone: _____

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Health History Questionnaire

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: _____

Do you have an Advanced Care Plan? Yes _____ **No** ____ **If yes, who is it?** _____

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:			Women 50+ Date of last mammogram?		
Chest Discomfort/Tightness with exertion			Liver Disease/Jaundice/Hepatitis			Dentures/Bridges/Caps		
Heart Attack-Date:			Kidney Disorder			Recreational Drugs		
Heart Failure-Date:			Myasthenia Gravis			Alcoholic Drinks per week		
Heart Murmur			Irregular Heart Beat-Date:			Years smoked ____ packs/day____		
Are there any personal or religious reasons you would refuse blood transfusions?			Thyroid Disease			Date stopped smoking:		
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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Please list all previous surgeries, hospitalizations, childbirth, medical illness:

Date (approx. year)	Reason	Place (hospital or city)

Current Medications/Vitamins	Dose	Route (mouth, injection, inhaler)	How often & when

Are you allergic to:	Yes	No	Reaction:	Are you allergic to:	Yes	No	Reaction:
Latex				Adhesive Tape			
Foods				Metal/Nickel			
Iodine on your skin				Other			

Medication Allergies:	Reaction:	Medication Allergies:	Reaction:

Signature of Patient/Legal Guardian_____ Date: _____

Patient Name: _____ DOB: _____

clg 03/12, 01/23, 5/23

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have been offered or have received a copy of Advanced Orthopedic Specialist's Notice of Privacy Practices. I have been informed that I can request a copy of the Notice of Privacy Practices at any time either by hard copy or by electronic mail.

_____

Patient's Printed Name

_____

Signature of Patient or *Personal Representative (if applicable) Date

_____

Personal Representative's Name (if applicable) Relationship to Patient

** The personal representative is the patient's decision maker if the patient cannot act for himself or herself. It can be the parent, legal guardian, or other person.*

For Internal Use Only

We attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices on the following date: _____, but acknowledgement could not be obtained because:

_____Patient/Personal Representative refused to sign.

_____Emergency situation prevented us from obtaining acknowledgment at this time. (An attempt to obtain acknowledgment will be made at a later time).

_____Other (Explain) _____