

Call – 586.627.1100

Fax – 586.627.1120



Kevin Hanlon, D.O.
James L. Kehoe, D.O.

Center for Orthopedic Surgery
21550 Harrington, Suite A
Clinton Township, MI 48036

Welcome to the Center for Orthopedic Surgery!

We are committed to serving you promptly and professionally. We do however need your help. In order for our office to properly evaluate your problem as well as facilitate the billing process, we ask your cooperation in providing us with accurate information about your health as well as insurance coverage.

The forms needed are on the proceeding pages of this document this gives you an opportunity to complete much of this information at home where you have access to your personal records. On the day of your appointment, we will need to verify that this information is accurate but **no more forms!!**

How Do You get the forms back to us?

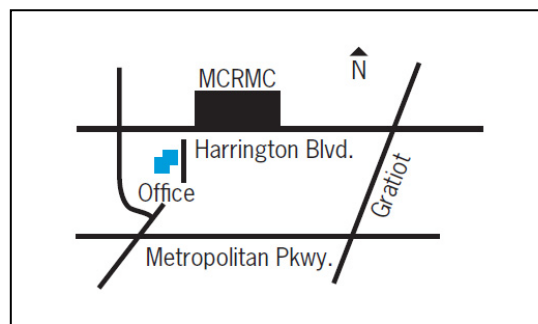
- 1- The forms are writable so you can email them to us at registration@ortho-surgery.com or use the submit button on the last page of the form.
- 2- Or you can print the completed forms and fax them to us at 586-627-1120
- 3- Or you can mail them to us at COS 21550 Harrington Suite A, Clinton Twp, MI. 48036
- 4- Bring completed form with you to appt. (This may hold up your appointment time, but is still faster than filling out the forms in the office)

Please be sure to get this information to us as soon as possible so we can be ready for you.

Patient Checklist for Day of Appointment

- * Please have the online registration form completed if not emailed, faxed or mailed.
- * Personal identification (photo ID) such as driver's license.
- * Current insurance card.
- * Referral or prescription if insurance requires (HAP, HMO, BCN, Mcare, etc.)
- * Parent/guardian if less than 18 years of age.
- * For a lower extremity problem (hip/knee/leg/ankle) you may bring shorts or wear clothing that can be easily removed for your examination.
- * For an upper extremity problem (neck/shoulder/elbow/forearm) you will want to wear a tank top or t shirt that allows access to your affected area.
- * Any current X-rays.
- * Any MRI or other imaging studies for area of concern.

We thank you for your cooperation and understanding.



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Today's Date: _____

Minor Child Patient Information Form

Patient Name: _____ Jr. Sr. II I
First Last Middle Initial

Home Address: _____ Apt: _____ City: _____ Zip: _____

Home Phone: _____ Sex: Male Female Birth Date: _____ SSN: _____

Student Status: Full Time Part Time School: _____

Preferred Language: _____ Ethnicity: Hispanic Non-Hispanic Race: _____

Primary Care Physician: _____

Responsible Party Information: *This is the person who brings the child in to the office.*

Name: _____ Date of Birth: _____
First Last Middle Initial

SSN: _____ Sex: Male Female Email: _____

Home Address: Same as Patients or _____
Address City State Zip

Home Phone: _____ Work Phone: _____ Ext _____ Other Phone: _____
 Cell Pager Fax Other

Employer: _____

Employment Status: Full Time Part Time Unemployed Self Employed Retired Active Military

Insurance Information

Effective Date: _____ Insurance Company: _____

Who holds the insurance: Self Spouse Child Other **If self checked skip this section, otherwise please complete.*

Name: _____ Date of Birth: _____
First Last Middle Initial

SSN: _____ Sex: Male Female Email: _____

Home Address: Same as Patients or _____
Address City State Zip

Home Phone: _____ Work Phone: _____ Ext _____ Other Phone: _____
 Cell Pager Fax Other

Employer: _____

Employment Status: Full Time Part Time Unemployed Self Employed Retired Active Military

Patient's Name: _____ Date of Birth: _____

*****Only complete this page if you have more than one insurance carrier.*****

If you only have one insurance than proceed to next page.

Secondary Insurance Information

Insurance Company: _____

Contract/ Policy/ ID # : _____ **Group:** _____ **Effective Date:** _____

Patient Student Status: Not a Student Full Time Student Part Time Student **Attending:** _____

Who holds the insurance: *Self Spouse Child Other **If self is checked skip this section, otherwise please complete.*

Name: _____ Date of Birth: _____	
First	Last Middle Initial
SSN: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Email: _____
Home Address: <input type="checkbox"/> Same as Patients / OR	
Address	City State Zip
Home Phone: _____	Work Phone: _____ Ext _____ Other Phone: _____
	<input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax <input type="checkbox"/> Other
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Military	

Insurance Company: _____

Contract/ Policy/ ID # : _____ **Group:** _____ **Effective Date:** _____

Patient Student Status: Not a Student Full Time Student Part Time Student **Attending:** _____

Who holds the insurance: *Self Spouse Child Other **If self is checked skip this section, otherwise please complete.*

Name: _____ Date of Birth: _____	
First	Last Middle Initial
SSN: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Email: _____
Home Address: <input type="checkbox"/> Same as Patients / OR	
Address	City State Zip
Home Phone: _____	Work Phone: _____ Ext _____ Other Phone: _____
	<input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax <input type="checkbox"/> Other
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Military	

If Medicare Secondary Check Reason:

- Working Aged Beneficiary or Spouse with Employer Group Health Plan
- End-Stage Renal Disease Beneficiary
- No-fault Insurance including Auto is Primary
- Black Lung
- Disabled Beneficiary Under Age 65 with Large Group Health Plan
- Other Liability Insurance is Primary

Patient Name: _____ Date of Birth: _____

Patient History Form

Height: _____ Weight: _____ Occupation: _____

Current Symptoms:

Current problem for this evaluation: _____

Body area (arm/leg/back/etc): _____ Right Left Both

When did your problem begin? _____

Have you had any treatment / x-rays? YES NO If yes, when? _____

By whom? _____ Where? _____

Is this problem related to an injury? YES NO

Current Medications: *Even if you are not currently taking any medications please provide the name of your preferred pharmacy so that we may better serve you.*

Pharmacy: _____ Phone: _____

Pharmacy Location: _____

Current List of ALL Medications You are Currently Taking - INCLUDING OVER THE COUNTER:

Name Of Medication:	Strength:	Dosage:

List ALL DRUG ALLERGIES: _____

Life Style

Physical Activity: Inactive Sedentary Moderately Active Extremely Active

Caffeine: Coffee Tea Amount/Day _____ Amount/Week _____

Tobacco: Cigar Cigarettes Smokeless Tobacco Amount/Day _____ Amount/Week _____

Alcohol: Beer Wine Other _____ Amount/Day _____ Amount/Week _____

Other Substances: List: _____

Patient Name: _____ Date of Birth: _____

Review Of Systems *Please check all that apply.*

Constitutional:

- Chills
- Fatigue
- Fever
- Weight Gain
- Night Sweats
- Weight Loss
- Other _____

Eyes:

- Blurry Vision
- Double Vision
- Dry Eyes
- Headache
- Visual Changes
- Eye Pain
- Other _____

ENMT:

- Dry Mouth
- Ear Pain/Pressure
- Altered Sense of Smell
- Hearing Loss
- Nasal Congestion
- Neck Pain/Stiffness
- Mouth Pain
- Post Nasal Drainage
- Sinus Pain/Pressure
- Sore Throat
- Ringing in Ears
- Trouble Swallowing
- Other _____

Cardiovascular:

- Hypertension
- Chest Pain
- Palpitation
- Fainting
- Heart Attack
- Heart Failure
- Heart Disease
- Atrial Fibrillation
- Other _____

Skin:

- Color Changes
- Dry Skin
- Knots/Skin Nodules
- Rashes
- Itchy Skin
- Skin Lesions
- Skin Ulcers
- Cellulitis
- Eczema
- Other _____

Gastrointestinal:

- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Blood in Stools
- Trouble Swallowing
- Rectal Pain
- Ulcer
- Nausea/Vomiting
- Weight Change
- Hepatitis
- Painful Urination
- Frequent Urination
- Reflux
- Other _____

Musculoskeletal: (Please indicate where)?

- Fracture _____
- Joint Instability _____
- Joint Pain _____
- Joint Swelling _____
- Joint Stiffness _____
- Muscle Weakness _____
- Muscle Pain _____
- Sprain _____
- Arthritis _____
- Tendonitis _____
- Osteoarthritis _____
- Other _____

Respiratory:

- Shortness of Breath
- Productive Cough
- Wheezing
- Asthma
- Emphysema
- COPD
- Other _____

Neurological:

- Dizziness
- Double Vision
- Coordination Problems
- Extremity Weakness
- Problems Walking
- Headache
- Numbness
- Seizure
- Fibromyalgia
- Fainting
- Stroke
- Paralysis
- Other _____

Psychiatric

- Anxious
- Nervous
- Depressed
- Nervous Breakdown
- Stress
- Sleeplessness
- Drug/Alcohol
- ADD/ADHD
- Other _____

Endocrine:

- Diabetes
- Lump in Neck
- Change in Hair Growth
- Hypoglycemia
- Thyroid
- Excessive Hunger/Thirst
- Heat/Cold Intolerance
- Other _____

Vascular/Lymphatic:

- Anemia
- Bleeding Tendency
- Lymph Node Pain/Enlargement
- Transfusions
- Cold Hands/Feet
- Poor Circulation
- Swelling
- High Cholesterol
- Other _____

Allergic/Immunologic:

- Metal Allergies
- Malignant Hyperthermia
- Allergic to Latex
- Anaphylactic Reaction
- Other _____

Hematologic:

- Anemia
- Hemophilia
- Excessive Bleeding
- Pulmonary Embolism
- Deep Vein Thrombosis
- Leukemia
- Blood Clots
- Stroke
- Bleeding Tendencies
- Other _____

Patient Name: _____ Date of Birth: _____

Complete Personal Medical History

Have you had any serious illness? YES NO

If YES, please list: _____

Past Surgeries? YES NO

If YES, please list: _____

Overall Health: Excellent Very Good Good Fair Poor

Family History: Does anyone of your close relatives (sisters, brothers, parents, grandparents, children, uncles, aunts) has/had any of the following diseases?

- Allergies Cancer Diabetes Venous Thrombosis
 Heart Attack Stroke Other chronic Diseases: _____

If any of your close relatives has died, at which age and from what cause has he or she died?

Mother	Age:	Cause of Death:
Father	Age:	Cause of Death:
Sister	Age:	Cause of Death:
Brother	Age:	Cause of Death:
Child	Age:	Cause of Death:
Grandmother	Age:	Cause of Death:
Grandfather	Age:	Cause of Death:

How did you hear about us?

- Physician: _____
 Phone Book
 Patient: _____
 Insurance Book
 Advertisement (where): _____
 Emergency Room or Hospital (which one): _____
 Other: _____

Certificate of Authenticity: I hereby certify the above information is true and correct to the best of my ability.

Signed: _____ Date: _____