**Center for Orthopedic Surgery P.L.C.**

21550 Harrington Suite A
Clinton Twp, MI 48036
Phone: (586) 627-1100
Fax: (586) 627-1120

8180 26 Mile Road Suite 102
Shelby Twp, MI 48316
Phone: (586) 627-1100
Fax: (586) 627-1140

Kevin Hanlon, D.O.

James Kehoe, D.O.

## Patient Information Sheet

Patient Last Name:_____ First Name:_____ Middle Init._____

Street Address:_____City:_____State:_____ Zip:_____

Telephone Number: (____)_____Social Security Number:_____ Height:_____ Weight:_____

Work Number: (____)_____ Cell Number:(____)_____Birth date:_____ Age:____ Sex:_____

Marital Status:_____ Employer:_____ Job Description _____

Your Family Physician:_____ Phone Number (  )_____

## Insurance Information

Subscriber's Last Name:_____ First Name:_____ Birth date:_____

Social Security Number:_____ Employer's Name:_____ Telephone Number:(____)_____

Employer's Address:_____

**I hereby authorize payment directly to Drs. Hanlon//Kehoe of the surgical and/or medical benefits payable to me for the services as described but not to exceed the reasonable and customary charges for those services.**
**I authorize any holder of medical or other information about me to release such information about me to release such information as necessary to process these claims or related medical claims.**
**I permit a copy of this authorization to be used in place of the original.**
**I understand I am financially responsible to the doctor for the charges not covered by this agreement and any late fees applied to the account.**

**Patient's Signature**:_____**Date**:_____

## Patient History

How did you hear about our practice?:_____

Current problem for this evaluation:
Body Part:_____ Right_____ Left____ Both____ Are you: Right/Left Handed

When did your problem begin? _____If an injury or accident, Date:_____ Auto/Slip & Fall/ Other

Has an attorney been consulted:_____ Is your problem a result of an accident? Yes No

Explain: How? When? Where?_____

_____

Have you had any Treatment/X-Rays? Yes No If so, by whom?_____

When?_____Where?_____

Do you have any Drug Allergies? Yes No Please List:_____

List any medications you are currently prescribed and reason for taking. Please include over the counter Medications:_____

_____

**OVER →**

## General Past Medical History

Have you had any serious illnesses? Yes No
Please List:_____

***Review of systems / medical history:***

*Other Orthopedic Problems:* **None** ☐ Arthritis___ Joint swelling ___ Tendonitis___ Sprain of _____
Other_____

*Circulatory Problems*: **None** ☐ Blood Clots_____ Phlebitis____ Stroke_____ Swelling_____
Other_____

*Heart Disease*: **None** ☐ Heart Attack____ Heart Failure_____ High Blood Pressure____
Other_____

*Respiratory Problems*: **None** ☐ Asthma____ Wheezing____ Short of Breath___ Emphysema___
Other_____

*Gastrointestinal Problems:* **None** ☐ Ulcer____ Diarrhea____ Nausea & Vomiting___ Weight Change___ Hepatitis___
Bloody Stool___ Other_____

*Genitourinary:* **None** ☐ Infection____ Pain of urination____ Frequency of urination___
Other:_____

*Neurological:* **None** ☐ Headaches___ Fainting____ Seizures____ Stroke____ Paralysis___ Numbness____
Head injury____ Other_____

*Emotional Problems:* **None** ☐ Nervous Breakdown___ Depression___ Stress___ Sleeplessness____
Drug/Alcohol____ Other_____

*Bleeding Problems:* **None** ☐ Other_____

*Endocrine / Metabolic:* **None** ☐ Diabetes___ Thyroid___ Hypoglycemia____ Other_____

*Genetic / Inherited Disorders:* **None** ☐ List_____

*Gynecological:* (females) Last Menstrual Period:_____ Last Pap_____ Pregnancies:_____

Complications:_____ Children:_____

***Past Surgeries:***
Please List;_____

_____

### Life Style

Caffeine: Coffee / Tea Amount per day_____ per week_____
Tobacco: Cigar / Cigarettes / Smokeless Tobacco Amount per day_____ per week_____
Alcohol/ **Beer:** Amount per day_____ per week_____ **Wine:** Amount per day_____ per week_____
Other substances: list_____

Do you consider your overall health as:
Excellent____ Very Good____ Good_____ Fair____ Poor_____ Other_____

### Certificate of Authenticity

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

Signed:_____ Date:_____

# Center For Orthopedic Surgery P.L.C

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Shelby Twp. MI 48316
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Fax (586)627-1140

Dr. Kevin Hanlon D.O.
Dr. James Kehoe D.O.

As the legal guardian of (patient name)_____ I authorize him/her to be seen by the Center For Orthopedic Surgery in the presence of the following individuals in the event of my absence.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Date: _____ Signature of Legal Guardian: _____

I hereby state all of the above information has not changed :

_____Initial _____Date

_____Initial _____Date

_____Initial _____Date

_____Initial _____Date

**OVER→**

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Dr. Kevin Hanlon D.O.
Dr. Ronald Meisel D.O.
Dr. James Kehoe D.O.

Patient

Legal Guardian/Relationship Date

I am the legal guardian of the above patient and allowed to make decisions on their medical care provided by Center For Orthopedic Surgery P.L.C., and in signing this document I have also agreed to assume responsibility for their account.

**Center for Orthopedic Surgery PLC**

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

21550 Harrington Ste A ~ Clinton Twp, MI 48036
Phone (586) 627-1100 Fax (586) 627-1120

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# Payment Policy Authorization

I understand that all charges incurred are my personal responsibility .I Authorize payment for services rendered to be paid directly to my Physician(s), and if correct information is supplied at the time of visit, that managed care insurance is filed with the contracted carriers. The Patient is responsible for all residual balances, including but not limited to co-pays, deductibles, coinsurance, master medical and charges not paid or covered by insurance for any reason, after consideration of contractual adjustments. There will be a $15 late fee and $5.00 statement fee applied monthly to any and all unpaid balances, these fees will be applied to my account immediately for not paying the above mentioned balances at the time they are in the office._____

**If your insurance company does not pay in full within 90 days the balance is due becomes your responsibility to obtain payment from your insurance company. We will assist you in any way but the balance WILL be transferred to you and remain on your side until the claim is paid.**_____

Surgical patients are required to pay their deductible and coinsurance amounts PRIOR to their scheduled surgery date unless otherwise stipulated by contract with a managed care insurer._____

In addition to the principle amount owed, I agree to pay 35% of the unpaid balance as collection fees if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and cover costs arising out of any litigation concerning the collection of this account._____

I acknowledge that I have fully read and understand all of the terms and conditions, as well as any payment terms associated with this contract and herby agree to be bound by all of the above terms.

If I have a **Master Medical** policy I understand that my office visit must be paid at the time of service, and give Center For Orthopedic Surgery my permission to submit the billing for my reimbursement.

If I am also a **Medicare patient**, I request payment of authorized Medicare benefits be made on my behalf to Center for Orthopedic Surgery for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents needed to determine these benefits payable for related services.

_____ _____

Patient Signature* Date

**Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is unable to sign or is a minor.