WORKMEN'S COMPENSATION INFORMATION SHEET
DRS. HANLON KEHOE

PATIENT INFORMATION

LAST NAME:_____FIRST NAME:_____MI:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

TELEPHONE NUMBER:_____SOCIAL SECURITY NUMBER:_____

BIRTHDATE:_____AGE:_____SEX:_____HEIGHT:_____WEIGHT:_____

EMPLOYER'S NAME:_____THROUGH TEMPORARY SERVICES?_____YES_____NO

IF YES, NAME OF TEMP SERVICE:_____

EMPLOYER/TEMP SERVICE ADDRESS:_____

CITY:_____STATE:_____ZIP:_____TELEPHONE NUMBER:_____

EMERGENCY CONTACT:_____TELEPHONE NUMBER:_____

ACCIDENT INFORMATION

Please complete the following questions in full. If any questions do not apply to you, please indicate with **N/A**. If you have any questions see the receptionist. We appreciate your cooperation.

WHO REFERRED YOU TO US?_____

CURRENT PROBLEM FOR THIS EVALUATION:

BODY PART:_____ ☐ RIGHT ☐ LEFT ☐ BOTH ARE YOU: ☐ RIGHT HANDED ☐ LEFT HANDED

EXACT DATE OF INJURY:_____TIME OF INJURY:_____

PLEASE EXPLAIN EXACTLY HOW THE INJURY OCCURRED:_____

_____

HAS AN ATTORNEY BEEN CONSULTED?_____YES_____NO

WHAT TREATMENT HAVE YOU HAD SO FAR FOR THIS INJURY AND BY WHOM?_____

_____

HAVE YOU HAD X-RAYS?_____YES_____NO WHEN?_____WHERE?_____

_____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND REASON FOR TAKING:_____

_____

DO YOU HAVE ANY ALLERGIES?_____YES_____NO (PLEASE LIST):_____

_____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR SURGERIES? (DIABETES, HEART DISEASE, CANCER?):_____

_____

I authorize Drs. Ferris / Hanlon / Meisel / Kehoe to release any necessary medical information about me to process these claims or related medical claims. I permit a copy of this authorization to be used in place of original. I understand I am financially responsible to the doctor for charges which are denied by the insurance company/employer.

SIGNATURE:_____DATE:_____

THANK YOU FOR HELPING US!

General Past Medical History:

Other Orthopedic Problems: ☐ None ☐ Rheumatoid or other arthritis ☐ Joint swelling_____ ☐ Pinched nerve

☐ Sprain of _____ ☐ Tendinitis_____ ☐ Other:_____

Circulation Problems: ☐ None ☐ Blood Clots ☐ Phlebitis ☐ Stroke ☐ Cold fingers or toes ☐ Swelling

Heart Disease: ☐ None ☐ Heart attack ☐ Chest pain ☐ Heart failure ☐ High blood pressure ☐ Other:_____

Respiratory Problems: ☐ None ☐ Asthma ☐ Wheezing ☐ Shortness of Breath ☐ Emphysema ☐ Other:_____

Gastrointestinal Problems: ☐ None ☐ Ulcer ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Loss of weight
☐ Bloody Stool ☐ Hepatitis

Genitourinary: ☐ None ☐ Infection ☐ Pain on urination ☐ Frequency of urination ☐ Other_____

Neurological: ☐ None ☐ Headache ☐ Fainting ☐ Seizures ☐ Stroke ☐ Paralysis ☐ Numbness ☐ Head injury

☐ Other:_____

Emotional Problems: ☐ None ☐ Nervous breakdown ☐ Depression ☐ Stress ☐ Sleeplessness ☐ Alcohol/Drug abuse

☐ Other:_____

Bleeding Problems: ☐ None or explain:_____

Endocrine / Metabolic: ☐ None ☐ Diabetes ☐ Thyroid ☐ Hypoglycemia ☐ Other:_____

Genetic or Inherited Disorders: ☐ None List:_____

Gynecological: (females) Last Menstrual Period:_____ Last Pap:_____

Pregnancies:_____ Complications:_____ Children:_____

Any Past Surgeries: Please list:_____

Life Style: Coffee / Tea / Caffeine beverages Amount_____/day

Tobacco: cigarettes / cigars / smokeless tobacco Amount_____/day

Other Substances:_____

Do you consider your overall health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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.

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

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

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

I,_____, give Center for Orthopedic Surgery permission to :

_____ To call my home about appointments

_____ To leave messages on my answering machine at _____

_____ To call my work place if necessary at _____

_____ To leave messages at my email address at_____

_____ May leave messages concerning appointments with _____

Relationship_____

_____ May discuss my medical condition with

_____

___ Release a copy of my medical records to

_____

_____

Patient or Legal Guardian's Signature:_____Date____

Witness:_____ Date:_____

- ***Authorizations expire 1 year from date of signature, unless stated otherwise***

Our office will NOT fax any confidential information unless deemed necessary and under the direction of the Privacy Officer for Center for Orthopedic Surgery.

Turn page over more information on the back→

Center For Orthopedic Surgery P.L.C.

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

Notice and Acknowledgement

Acknowledgement Waiver

I acknowledge that I have waived my right to receive a copy of the Notice of Privacy Practices at this time and may receive a copy at a later date. I am aware that Center for Orthopedic Surgery requires my signature to release my protected health information on a separate form and will NOT release my confidential information unless under my authorization.

_____

Patient Or Legal Representative Date

Acknowledgement:
I acknowledge that I have received the attached Notice of Privacy Practices.

_____

Patient or Legal Representative Date

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

8180 26 Mile Rd Ste 105 ~ Shelby Twp, MI 48316
Phone (586) 627-1100 Fax (586) 627-1140

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.