PATIENT INTRODUCTION

Date of Injury: _____

How did you hear about us?

PLEASE PRINT

PATIENT

Mr./Mrs./Ms.

Patient Last Name	First Name	Middle

Sex	Date of Birth	Social Security Number
		- -

Address	Apt. No.	City	State	Zip Code

Home Phone	Work Phone	Mobile Phone	Marital Status
( )	( )	( )	S M W D

Home Work
Mobile Portal

E-Mail	Contact Preference (Please Circle)	Primary Language	Race	Ethnicity

Referring Physician Name	Address	City	State	Zip Code

Employer	Employer's Address	City, State	Zip Code	Occupation

Spouse's Name	Employed By	Employer's Address	Bus. Phone

Drivers License Number	Exp. Date	Primary Care Physician

RESPONSIBLE PARTY

***RESPONSIBLE PARTY**

Please complete the section below, if someone other than the patient is responsible for the payment of services.
Our office considers a patient to be responsible for their own bill if they are 18 years of age or older.
For children under age 18, the parent who brings the patient to the appointment is considered to be the responsible party.

Mr./Mrs./Ms.

Last Name	First Name	Relationship to patient

Address	Apt. No.	City	State	Zip Code	Phone No.

Employer	Employer's Address	City, State	Zip Code	Bus. Phone No.

Social Security No.	Date of Birth
- -	

*The policy of our office is: the parent who requests treatment for the child is responsible for all fees for service rendered.

INSURANCE

PRIMARY INS CO:		SECONDARY INS CO:	
Policy Holder Name:		Policy Holder Name:	
Employer:		Employer:	
Date of Birth:		Date of Birth:	
Relationship to patient:		Relationship to patient:	
Effective Dates:	/	Effective Dates:	/
	to/ from		to/ from

Is this injury work or auto related? Yes / No

THE FOLLOWING STATEMENT MUST BE SIGNED PRIOR TO TREATMENT

I have completed this form completely and certify that I am the patient or duly authorized general agent of the patient. I authorize the release of pertinent medical information to my insurance carrier and authorize my insurance benefits to be paid directly to Jeffrey H. DeClaire, MD PC DBA DeClaire LaMacchia Orthopaedic Institute (DLOI) which accepts assignment. I understand that even though I may have insurance coverage, I am responsible for payment of services. DLOI agrees to bill my insurance as a courtesy and that I must submit information as needed to ensure payment for services. I authorize DLOI to contact me by telephone and/or other means to remind me of my appointments and past due balances.

Date (today) _____ Signature of Patient or Responsible Party _____

DECLAIRE LAMACCHIA ORTHOPAEDIC INSTITUTE | MOVESTRONG MEDICINE FOR MOVEMENT

ORTHOPAEDIC HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

Is the current problem the result of a(n) ☐ Car Accident ☐ Work Accident ☐ Other

Date of injury: _____ Please Describe: _____

Person to notify in case of an emergency:

Name: _____ Relationship: _____ Phone: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers. We will electronically obtain past pharmaceutical history from the nationally approved repository, Sure Scripts.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.
Please check the appropriate box for the following. Latex allergy? [ ] Yes [ ] No Metal allergy? [ ] Yes [ ] No

	ALLERGY	REACTION
1.		
2.		
3.		

Primary Physician: _____ Address: _____

Referring Physian: _____ Address: _____

FAVORITE PHARMACY

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ COPD-Chronic Obstructive Pulmonary Disease
- ☐ Cancer-Malignant neoplastic disorder
- ☐ Claustrophobic
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ General Anesthesia adverse reaction
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism (over active)
- ☐ Hypothyroidism (under active)
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke-Cerebrovascular accident
- ☐ Tuberculosis
- ☐ Other problem: Please list condition

Have you ever had general anesthesia? ☐ No ☐ Yes

Have you or any member of your family ever had problems with anesthesia? ☐ No ☐ Yes Please describe:_____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	DOCTOR/HOSPITAL
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

FAMILY HEALTH HISTORY

Please list current age of living relative. If relation is not living, please list deceased age.

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____
Father	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____
Mother	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____
Brother/Sister-Please circle	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____
Brother/Sister-Please circle	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke-CVA ☐ Other_____

SOCIAL HISTORY

Occupation

_____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level ☐ None (No exercise) ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, please list:

_____

Tobacco

Do you use tobacco?
☐ Yes ☐ No
If not currently, did you ever use tobacco? ☐ Yes ☐ No
Age of first tobacco use_____
☐ Cigarettes - _____pks./day
☐ Chew - _____/day
☐ Cigars - _____/day
☐ # of years_____
Or year quit _____

Alcohol

Do you drink alcohol?
☐ Yes ☐ No

If so, how often?
☐ Occasionally
☐ < 3 times a week (mod)
☐ > 3 times a week (heavy)

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

# of cups/cans per day? _____

Activities of Daily Living

Able to care for self? Y/N
Deaf or serious hearing difficulty? Y/N
Difficulty concentrating, remembering or making decisions? Y/N
Difficulty doing errands alone? Y/N
Difficulty dressing or bathing? Y/N
Difficulty walking or climbing stairs? Y/N
Live alone or with others? alone/others

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
☐ Frequent Sneezing
☐ Hives
☐ Itching
☐ Runny Nose
☐ Sinus Pressure

Cardiovascular
☐ Arm Pain on Exertion
☐ Chest Pain on Exertion
☐ Chest Heaviness/Pressure on Exertion
☐ Irregular Heart Beats (Palpitations)
☐ Known Heart Murmur
☐ Light-headed on Standing
☐ Shortness of Breath When Lying Down
☐ Shortness of Breath When Walking
☐ Swelling (edema)

Constitutional
☐ Exercise Intolerance
☐ Fatigue
☐ Fever
☐ Weight Gain (____lbs)
☐ Weight Loss (____lbs)

Eyes
☐ Dry Eyes
☐ Irritation
☐ Vision Change
Date of Last Exam:_____

Ears/Nose/Mouth/Throat
☐ Bleeding Gums
☐ Difficulty Hearing
☐ Dizziness
☐ Dry Mouth
☐ Ear Pain
☐ Frequent Ear Infections
☐ Frequent Nosebleeds
☐ Hoarseness
☐ Mouth Breathing
☐ Mouth Ulcers
☐ Nose/Sinus Problems
☐ Ringing in Ears

Endocrine
☐ Fatigue
☐ Increased Thirst/Hunger/Urination
☐ hair loss
☐ Increased hair growth
☐ cold intolerance

Gastrointestinal
☐ Abdominal Pain
☐ Black or Tarry Stool
☐ Blood in Stool
☐ Change in Appetite
☐ Frequent Indigestion
☐ Hemorrhoids
☐ Trouble Swallowing
☐ Vomiting
☐ Vomiting Blood
☐ frequent diarrhea

Genitourinary
☐ Blood in Urine
☐ Difficulty Urinating
☐ Incomplete Emptying
☐ Increased Urinary Frequency
☐ Urinary Loss of Control

Hematologic/Lymphatic
☐ Easy Bruising/Bleeding
☐ Swollen Glands

Integumentary (Skin)
☐ Changes in Moles
☐ Dry Skin
☐ Eczema
☐ Growth/Lesions
☐ Itching
☐ Jaundice (Yellow Skin/Eyes)
☐ Rash

Musculoskeletal
☐ Back Pain
☐ Joint Pain
☐ Muscle Aches
☐ Muscle Weakness
☐ Swelling in the extremities

Neurological
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Memory Loss
☐ Migraines
☐ Numbness
☐ Restless Legs
☐ Seizures
☐ Weakness
☐ Loss of conciousness

Psychiatric
☐ Alcohol Overuse
☐ Anxiety/Stress
☐ Depression
☐ Do Not Feel Safe in Relationship
☐ Sleep disturbances
☐ Restless sleep
☐ Mania

Respiratory
☐ Cough
☐ Coughing Up Blood
☐ Shortness of Breath
☐ Sleep Apnea
☐ Snoring
☐ Wheezing

Other: Please describe

_____
_____
_____

_____
Patient, Parent, Guardian, or Caregiver Signature

_____
Date

DECLAIRE LAMACCHIA ORTHOPAEDIC INSTITUTE | MOVESTRONG™ MEDICINE FOR MOVEMENT

Patient Authorization for Personal Representative

Name of Practice: DeClaire LaMacchia Orthopaedic Institute

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual(s) who is (are) authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

Name of Personal Representative _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

Name of Personal Representative _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

- Description of information to be disclosed: I authorize the practice to disclose all of my protected health information to my designated personal representative.
- Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to: DeClaire LaMacchia Orthopaedic Institute, Attention: Privacy Manager, 1135 W. University Dr. Suite 450, Rochester, MI 48307

Re-disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____ _____

Signature of Patient/Personal Representative Printed Name of Patient/Personal Representative

_____

Date

DECLAIRE LAMACCHIA ORTHOPAEDIC INSTITUTE | MOVESTRONG MEDICINE FOR MOVEMENT

RECORDS RELEASE AUTHORIZATION

To: Physician or facility name:_____

Address:_____

Telephone Number:_____

Fax Number:_____

I hereby authorize and request you to release the complete history records in your possession, concerning my illness and/or treatment during the period:

From:_____ To:_____

to the DeClaire LaMacchia Orthopaedic Institute.

DeClaire LaMacchia Orthopaedic Institute
1135 W. University Dr.
Suite 450
Rochester, MI 48307
T (248) 650-2400
F (248) 650-4596

Patient Name:_____ Patient date of birth:_____

Address:_____

Signature:_____

Printed name of signature and relationship to patient:_____

Date:_____

Witness:_____

DECLAIRE LAMACCHIA ORTHOPAEDIC INSTITUTE | MOVESTRONG MEDICINE FOR MOVEMENT

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned Patient or Legally Authorized Representative (Agent or Guardian) of the Patient acknowledges that he or she has been offered a copy of the DeClaire LaMacchia Orthopaedic Institute's Notice of Privacy Practices on the date indicated below.

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

For Office Use Only:

_____ Patient/Representative Unable to Sign-Notice of Privacy Practices Provided.

_____ Patient/Representative Refused to Sign-Notice of Privacy Practices Provided.

_____ Other: _____

Signature: _____ Date: _____

Print Name: _____

At the DeClaire LaMacchia Orthopaedic Institute, we feel the doctor/patient relationship is built on mutual trust, respect and our concern for your health care. As such, we strive to be respectful of the time for your scheduled appointments, and ask that you give us the same courtesy. Missed appointments and "no-shows" are disruptive and more importantly create slot that could have been used by another patient in need. We understand however, that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment.

CMS, Centers for Medicare & Medicaid Services, have published a notice providing new guidance on billing Medicare patients for missed appointments. Under the current guidelines, Medicare allows a no-show fee as long as the practice:

- Has a written policy on missed appointments that is provided to all patients.
- Ensures that the missed appointment policy applies equally to all patients.
- Establishes that the billing staff is aware that Medicare beneficiaries should be billed directly for missed appointments.
- Ensures that charges for missed appointments are reflective of a missed business opportunity and not the cost of the service itself.

If you are unable to keep your scheduled appointment, we require a 24-hour notice (1-full business day) so that we may accommodate the needs of another patients. If an appointment is cancelled or rescheduled within 24 hours of the reserved appointment time, DeClaire LaMacchia Orthopaedic Institute will charge the patient a cancellation fee of $50.00. As a last resort, patients who miss more than 3 appointments will be terminated from the practice.

Jeffrey H. DeClaire, MD & John E. LaMacchia, MD
DeClaire LaMacchia Orthopaedic Institute

_____ _____

Name Date

DeCLAIRE LaMACCHIA ORTHOPAEDIC INSTITUTE

Patient Financial Responsibility Policy

DeClaire Lamacchia Orthopaedic Institute (DLOI) appreciates the confidence you have shown in choosing us to provide for your orthopaedic needs. We are privileged and honored to provide you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask if you have any questions regarding your financial responsibility.
Our receptionist may ask to see your insurance card at every visit and will scan your card into our system as needed to keep our information current and to facilitate accurate insurance billing.

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided in full.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

REFERRALS

If your insurance plan requires a referral form from your Primary Care Physician, **it is the patient's responsibility** to obtain your referral prior to your appointment and to have it with you at the time of your appointment. If you don't have the referral, **YOU MAY BE REQUIRED TO RESCHEDULE.**

AUTOMOBIE ACCIDENT/WORKER'S COMP CASES

Patients shall be financially responsible for medical services related to automobile/worker's comp. It is the responsibility of the patient to notify DLOI of the date of injury, claim #, insurance company address, phone number and contact person. If your motor vehicle claim exhausts, or your worker's comp claim denies, it will be the patient's responsibility to submit to DLOI any other insurance plan that you may have, or the charges will be considered the patient's responsibility. If your insurance plan is a non-participating plan with DLOI, and your motor vehicle exhaust or worker's comp denies, you will be responsible for any unpaid charges.

FINANCIAL RESPONSIBILITY OF PATIENT

I understand that if I do not make payment for services rendered, DLOI will take all necessary and appropriate action to collect any money due from me to DLOI, but not limited to the use of collection agencies, or attorneys. I will be responsible for any and all fees associated with these collection efforts. **WE ACCEPT CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND CHECKS. CARE CREDIT IS ALSO AVAILABLE.** I hereby authorize DLOI to release all medical information to insurance carriers concerning my illness and treatment and I hereby assign payment to DLOI for services rendered to myself/my dependent. I understand **I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY MY INSURANCE.**

_____ _____

Signature of patient, Power of Attorney, or Guardian if minor **Date**