MICHIGAN ORTHOPAEDIC SPINE SURGEONS
1555 E South Blvd. #310 Rochester Hills, MI 48307
Phone (248)215-8080 Fax (248)289-1085

OFFICE POLICIES

We have reserved_____ for you to have a consultation with:

Richard W. Easton, M.D.	Brent Lotterman PA-C
Bradley D. Ahlgren, M.D.	Michael Broad PA-C
Brady T. Vibert, M.D.	Brandon Mackenzie PA-C
Christopher A. Hulen, M.D.	Thomas Klick Jr. PA-C
Nicholas S. Papakonstantinou, M.D	
John S. Papakonstantinou, M.D	
Nathan A. Rimmke, M.D	

Please take the time to fill out the enclosed forms completely. Failure to do so may delay your visit. Please **ARRIVE AT YOUR SCHEDULED APPOINTMENT TIME** to allow time for our staff to verify all insurance and paper work.
If you have a co-pay or deductible, payment is due at the time of check in.

Please obtain all testing from your referring doctor and/or primary care physician. You will also need to bring any X-rays, CDs of MRIs, CT Scan, Myelograms. Failure to do so may cause your appointment to be rescheduled.

Other required information to bring to your appointment;

1. Photo ID
2. All insurance cards
3. An updated medication list with the dose and frequency
4. A referral or authorization if one is needed, If not obtained by the time of your visit; your appointment will be rescheduled.
5. If this is a Workers Compensation or Auto Claim, a Letter of Authorization or Open Claim Letter or Notice of Dispute is needed **prior to your appointment**. Without this information your appointment will be rescheduled.
6. Any relevant insurance **NOT** disclosed at the time of appointment will not be processed or billed at a later date.

If you need to cancel your appointment, please contact our office. If you arrive late to your scheduled appointment time, your appointment may be rescheduled at the discretion of our doctors.

I acknowledge that I have read and/or received a copy of this policy. I agree to the terms listed within

SIGNATURE:_____**Date:**_____

Effective Date: April 14,2003

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Michigan Orthopaedic Spine Surgeons
Richard W. Easton, M.D.
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Nathan A. Rimmke, M.D.

I have received a copy of the Notice of Privacy Practices for the above named physicians.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Name of Patient Representative (Print or Type) Relationship

_____
Signature of Patient Representative Date
(Required if the patient is a minor or an adult who is unable to sign this form)

Additional Authorization

In addition to the practices outlined in our Privacy Notice, I gave the above named physicians my authorizations to release my personal medical and or financial information to:

_____
Name (Print or Type) Relationship

_____
Patient Signature Date

PATIENT INFORMATION SHEET

PATIENT NAME: _____ **SPOUSE NAME:** _____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

PARENT/GUARDIAN NAME (IF PATIENT IS A MINOR): _____

HOME ADDRESS: _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

HOME PHONE: (_____) _____ **PATIENT BIRTH DATE:** _____ **AGE:** _____ **SEX:** _____

***PATIENT* SOCIAL SECURITY #:** _____ **MARITAL STATUS** (CIRCLE) S M W D

PATIENT EMPLOYMENT STATUS (CIRCLE) Full Time / Part Time / Not Employed / Retired - Date _____

STUDENT STATUS (If applicable - Circle) Full Time / Part Time / Not a Student

***PATIENT* EMPLOYER** _____ **PHONE NO.** (_____) _____

PATIENT OCCUPATION _____ **PRESENTLY EMPLOYED?** YES / NO

EMERGENCY CONTACT ***(SOMEONE NOT LIVING WITH YOU)***

NAME: _____ RELATIONSHIP: _____ PHONE: (____) _____

RESPONSIBLE PARTY INFORMATION : (IF OTHER THAN PATIENT) RELATIONSHIP TO PT: _____

NAME: _____ SEX: MALE / FEMALE

ADDRESS: _____
(NUMBER) (STREET) (CITY, STATE, ZIP)

HOME PHONE: (_____) _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

EMPLOYER: _____ PHONE: (_____) _____

REASON FOR SEEING DOCTOR: _____

DATE OF INJURY OR ONSET: _____ **HOW DID IT HAPPEN?** _____

IS THIS INJURY DUE TO AN AUTO ACCIDENT? YES / NO
DID THIS INJURY HAPPEN AT WORK? YES / NO

REFERRED BY: _____

FAMILY DOCTOR/PCP: _____ PHONE: (_____) _____

ADDRESS: _____
(NUMBER) (STREET) (CITY, STATE, ZIP)

PLEASE GIVE THE RECEPTIONIST THE FOLLOWING:

1) ALL your insurance cards
2) Driver's License/Picture ID
3) X-rays/Reports
4) Your HMO referral (if applicable)
5) Your Workers Comp Letter of Authorization (if applicable)

I confirm that all the information furnished is complete and accurate as of: _____
(Date)

PATIENT OR GUARDIAN SIGNATURE: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Name: _____

Subscriber's Name: _____ **Date of Birth:** _____

Employer: _____ **Retired?** _____ **When:** _____

Secondary Insurance Name: _____

Subscriber's Name: _____ **Date of Birth:** _____

Employer: _____ **Retired?** _____ **When:** _____

Third Insurance Name: _____

Subscriber's Name: _____ **Date of Birth:** _____

Employer: _____ **Retired?** _____ **When:** _____

Workers Comp/Auto: **Employer/Subscriber:** _____

Name of Insurance Co: _____ **Phone (___)** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Claim # _____ **Name of Adjuster:** _____

MEDICARE PATIENTS- PLEASE READ AND SIGN BELOW:

I, _____, Medicare # _____ request payment of authorized Medicare benefits be made on my behalf to Michigan Orthopaedic Spine Surgeons, P.C. for services furnished and authorize to the Health Care Financing Administration any information needed to determine these benefits. I understand I will be responsible for all co-pays and deductibles not covered by my insurance(s).

COMMERICAL/BCBS/WORKERS COMP/AUTO INSURANCE PATIENTS- PLEASE SIGN BELOW

I authorize the release of medical information necessary to process my claims and also authorize payment of medical benefits to Michigan Orthopaedic Spine Surgeons, P.C. for services furnished to me (or my dependent if a minor). Commercial/BCBS- I also understand that I will be responsible for all my co-pays and deductibles not covered by my insurance(s).

_____ _____

Print Patient Name Patient Date of Birth

_____ _____

Patient/Parent Signature Date

Date:_____

E-PRESCRIBING

To allow your medications to be electronically submitted to your pharmacy.

Patient Name: _____

Patient Date of Birth:_____

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone #:_____

PAIN SCALE

(PLEASE USE SCALE FOR FOLLOWING QUESTIONS)

	SYMPTOMS
1 (ONE)	Pain free
2 (TWO)	Very minor annoyance—I have occasional minor twinges
3 (THREE)	Annoying enough to be distracting
4 (FOUR)	Can be ignored if busy, but still distracting
5 (FIVE)	Can't be ignored for more than 30 minutes
6 (SIX)	Can't be ignored for any length of time but can still work and do social activities
7 (SEVEN)	Makes it difficult to concentrate, interferes with sleep, can function with effort
8 (EIGHT)	Physical activity severely limited, can read and speak with effort, experience nausea and dizziness
9 (NINE)	Unable to speak, crying out or moaning uncontrollably
10 (TEN)	Either unconcious or it makes you want to pass out

PLEASE COMPLETE ALL FORMS FOR YOUR APPOINTMENT

Michigan Orthopaedic Spine Surgeons

New Patient Evaluation

Patient's Name _____ **Date of Birth** _____ **Today's Date** _____

Primary Medical Physician _____ **Referring Physician** _____

Age:_____ Height_____ Weight _____Blood Pressure _____

Allergies _____

_____

Latex Allergy? Y / N Work Related Y / N Auto Related Y / N Date of Injury _____

Complaint or Problem: Cervical Thoracic Lumbar Extremity_____

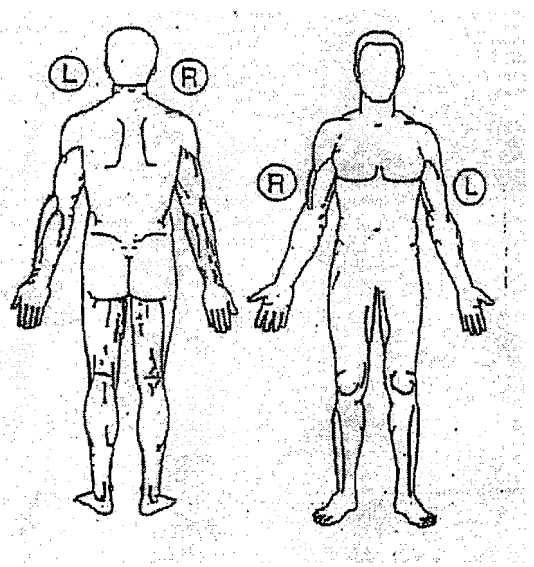
Date of Onset: _____ **Onset:** Sudden Gradual Spontaneous

Initiating Event: Fall Sports Exercise Unknown

Extended Care Facility:
Are you currently residing in an Extended Care Facility? Yes or No

If yes name of Facility: _____

Use the picture below to shade the location of the pain



Pain %-
Neck-
Arm-
Back-
Buttock-
Leg-

AAAA- aching
SSSSS- stabbing
NNNN- numbness
PPPPP- pins and needles
TTTTT- tingling

Explanation:

In the boxes below please circle all that apply to your complaints/condition.

Neck/Back Quality of Pain	Pain Radiating	Associated/Other Symptoms
• Achy • Burning • Cramping • Deep • Dull • Heavy • Sharp • Shooting • Throbbing • Tight	• Back of head • Front of head • Side of head R/L • Right arm • Left arm • Right hand • Left hand • Right leg • Left leg • Right foot • Left foot • Buttock	• Bowel/bladder changes • Difficulty swallowing • Numbness • Spasms • Stiffness • Tingling • Weakness • Other _____
Symptoms Improved With	**Symptoms Worse With**	**Treatment you have tried**
• Heat • Changing body position • Cold • Exercising • Lying down • Resting • Sleeping • Standing • Stopping activity • Walking • Other _____	• Bending • Changing body position • Cold • Exercising • Heat • Lifting • Lying down • Pushing/pulling • Resting • Sitting • Standing • Stopping activity • Walking • Other _____	• On restrictions • Acupuncture • Anti-inflammatory medications • Chiropractic • Epidural Steroid injections • Herbal medications • Hot packs • Massage • Medrol dose pack • Muscle relaxants • Narcotics • Pain management • Physical therapy • TENS unit • Other _____

Rank pain level on a scale of 0-10.

Neck/Back with Medication:	0	1	2	3	4	5	6	7	8	9	10
Neck/Back without Medication:	0	1	2	3	4	5	6	7	8	9	10
Arm/Leg with Medication:	0	1	2	3	4	5	6	7	8	9	10
Arm/Leg without Medication:	0	1	2	3	4	5	6	7	8	9	10

Past Medical History – Circle all that apply

- Alcoholism
- Anemia
- Asthma
- Benign Prostate Hypertrophy
- Bleeding Disorder
- Blood Clot in Leg
- Congestive Heart Failure
- Diabetes
- Heart Murmur
- COPD
- Irregular Heart Beat
- Kidney Disease
- Liver Disease
- Myocardial Infarction
- Osteoarthritis
- Pacemaker/ ICD
- Peripheral Vascular Disease
- Reflux
- Rheumatoid Arthritis
- Thyroid Disease
- Hepatitis
- Tuberculosis
- Ulcers
- Elevated Cholesterol
- Seizures
- Sleep Apnea
- Stroke/ Transient Ischemic Attack
- Hypertension

Please list your past surgical history:

Family History:

- Stroke
- Arthritis
- High Blood Pressure
- Diabetes
- Bleeding Disorder
- Cancer
- Alcoholism

Social History: Circle all that apply

Tobacco Use

- I have never smoked
- I used to smoke, but I quit on _____
- I currently smoke _____ packs per day for _____years.
- I chew tobacco
- Medical Marijuana

Alcohol

- Never
- Seldom
- Minimal
- Moderate (Weekly)
- Heavy (Daily)

Employment Status:

Occupation_____

Disabled Yes or No Date Disability began_____ Permanent or Temporary

Restrictions:

_____

Review of Systems: Circle all that currently apply

- Chest Pain
- Cough
- Difficulty Swallowing
- Fever/ Chills
- Fatigue
- Nausea/ Vomiting
- Shortness of Breath
- Ulcers
- Recent Weight Change
- Other_____
- _____

Brace: Type_____ Dispensed_____ Script given_____

Medication Record

Patient Name:_____ Date of Birth:_____

Physician prescribing pain medication/pain management physician:_____

Name of Medication (Prescriptions, over the counter eye drops, supplements, patches, herbals, inhalers, implanted pumps)	**Dose of Medication** (Example: one 20mg tablet)	**How Often Do You Take This Medication?** (Examples: three times a day, at bedtime)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Pain Management Specialists
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Jarman Dr
Burdic Dr
Chancery Dr
Stirling Dr
Gulliver Dr
Alfred Dr
Lyster Ln
Merald Shores Dr
Edith St
Ravenna Dr
Donald J. Flynn Park
Sanctuary Lake Golf Course
William Beaumont Hospital
Dequindre Rd