Allegan Orthopedic &
Sports Medicine Center

551 Linn Street, Ste. 220 • Allegan, MI • 49010

Date: ____________________ **(for office use only) Account number:** ______________
Name: ____ Date of Birth: ______________
Address: _____________________________________ City: __________________ State: ________
Zip: ________________ Home Phone: ___________________ Cell Phone: ___________________
Social Security #: ________________________ Email: ___________________________________
Marital Status: __________________Employer: ____
Driver's License #: ____________________ Primary Care Doctor: __________________________
Referring Provider (if different than primary): ____
Pharmacy Name: _____________________________________ Phone Number: _______________
Pharmacy Address: ____
Employer Name: ______________________________________ Phone Number: _______________
Employer address: ____

If patient is a minor or full-time student, please complete the following: (if different from above)
Parent's Name: ____________________________________ Date of Birth: ___________________
Address: _____________________________________ City: __________________ State: ________
Zip: ________________ Home Phone: ___________________ Cell Phone: ___________________
Employer: ___________________________________ Social Security #: ___________________

Emergency Contacts:
Name: ________________________________ Phone: ________________ Relationship: _________
Name: ________________________________ Phone: ________________ Relationship: _________

U.S. Government Reporting:
I would prefer not to disclose this information ☐
Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Type Unknown
Ethnicity: ☐ Hispanic ☐ Non-hispanic ☐ Type Unknown
Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ Japanese

I agree Allegan Orthopedic & Sports Medicine Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Signature: ____ Date: ___________________

FOR OFFICE USE ONLY:
Reviewed by: ____ Date: ___________________

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Patient Name: ____ **Date of Birth:** ______________

Review of Systems: Are you (or the child) currently having or have you had problems with your (check boxes that are positive and explain if necessary):

☐	Fatigue	☐	Irregular heartbeat	☐	Anemia
☐	Fever	☐	Heart murmurs	☐	Bleeding problems
☐	Weight Loss	☐	Nausea	☐	Numbness or Tingling
☐	Headache	☐	Vomiting	☐	Dizziness
☐	Blurred Vision	☐	Constipation	☐	Headaches
☐	Corrective Lenses	☐	Diarrhea	☐	Rashes
☐	Congestion	☐	Incontinence	☐	Skin disorders
☐	Hearing loss	☐	UTI	☐	Connective Tissue disorder
☐	Jaw discomfort	☐	Difficulty urinating	☐	Change in mood/behavior
☐	Shortness of breath	☐	Diabetes	☐	Change in sleep patterns
☐	Wheezing	☐	Thyroid problems	☐	Asthma
☐	Cough	☐	Growth delays	☐	Communicable diseases
☐	Chest pain	☐	Joint pain	☐	Hay fever
☐	HIV	☐	Hepatitis A, B, or C	☐	Other __________________

Allergies: ____

Past Surgeries: ____

____

____

Medications: ____

____

____

Height: ____________________Weight: _________________

Date of Injury: _________________ Problem/Injury: _____________________________

How did it occur?: ____

Were X-Rays taken? ☐ Yes ☐ No Date of X-rays: ____________ If yes, where? _____________

MRI: Date & Place ________________ CT Scan: Date & Place ___________________________

Current problem is a result of a: Check all that apply: ☐ car accident ☐ work accident

☐ Other (please explain): ____

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Name: ____Date of Birth: ___________

Have you ever had general anesthesia? ☐ No ☐ Yes

Have you had any problems with general anesthesia? ☐ No ☐ Yes

If yes, please describe: ____

Have you had any problems with bleeding? ☐ No ☐ Yes

If yes, please describe: ____

Past Family History:

Relation	Alive (age)	Deceased (age)	Cause of Death	Health Problems

Social History:

Occupation: ____

Tobacco use? ☐ No ☐ Yes Type/Amount per day/week: ____________________

Alcohol use? ☐ No ☐ Yes Amount per day/week: _________________________

Drug use? ☐ No ☐ Yes Amount per day/week: _________________________

NO SHOW POLICY

Our office considers appointment times to be of utmost importance for the best care and outcome of our patients. Effective immediately, a $25 fee will be charged to each patient that fails to show for their appointment or give a 24 hour cancellation notice. After the third missed visit, patients will be discharged and will need to seek care elsewhere.

By signing below, I acknowledge understanding and cooperation with the above statement.

Signature: ____ Date: ________________

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Name: ____Date of Birth: ______________

PRIVACY RIGHTS

We appreciate the trust you have placed in us. One of the ways we will protect that trust is by respecting the privacy of all our patients. We are required by federal and state law to maintain the privacy of your health information. Federal and state laws allow us to use your health information for treatment, payment and for other limited uses. We cannot use or disclose your health information for any reason not allowed by law unless you give us written permission.

In general, the privacy law gives you the right to request a restriction on the use and disclosure of your Protected Health Information (PHI). The law does not allow us to speak to a member of your family, another relative, or a close friend who may be involved in your care unless you request in writing that we do so. A complete description of our privacy notice is on display in the reception room, on our website at http://alleganorthopedics.com/pdfs/hipaa.pdf or available from our receptionist.

I authorize Allegan Orthopedics & Sports Medicine Center to disclose Protected Health Information for appointment or other healthcare purposes to the following people. If you don't want to list anyone please circle. NONE

____

Name Phone Number Relationship

____

Name Phone Number Relationship

____

Name Phone Number Relationship

Please note if you do not provide the correct insurance information, it may be possible you will be responsible for all charges that are incurred during your visit and treatment here. Correct insurance information is very important as we use this information to obtain important authorizations for your treatment and care here. If we are unable to get authorization for your treatment here due to the lack of correct insurance information, you may be responsible for complete charges.

Please sign below stating you understand this & will provide correct information.

Signature: ____ Date: ________________