CHECK LIST FOR APPOINTMENT:

As a new patient to our practice, we would like to welcome you and provide you with important information. Please review the items needed for your appointment to ensure that your experience is efficient and satisfactory.

Your appointment date:_____time:_____

Doctor:_____Location:_____

If you have completed this packet, including the OMR Bubble Sheet, please bring it with you and arrive 10-15 min prior to your first appointment. **If you did not complete the packet, including the OMR Bubble Sheet ahead of time then you MUST arrive to the office 30 minutes early to fill out all necessary paperwork.**

In addition to the New Patient Packet you must also bring the following:

- ✓ Picture ID (drivers license or state ID)
- ✓ Insurance Cards. If you have an HMO, you MUST bring a referral with you if required (most office will no longer fax referrals). You will NOT be seen without a referral.
- ✓ Your Copay and Deductible (if applicable). Our financial policy is located on our website under the "Patient Forms" tab.
- ✓ Work-Related or Auto-Related injuries require a written letter of open claim. This letter must include the claim #, billing address, name and phone number of contact person (case manager).
- ✓ If you have underwent diagnostic testing (ie., Xrays, MRI, CT, EMG, etc.) prior to your appointment then you must bring the actual images to your appointment. Radiology Reports alone are not acceptable. Please bring the images via hard films/hard copy or CD of images.
- ✓ List of medications, supplements, allergies.
- ✓ Primary Care Doctor, Referring Doctor, and Cardiologist (if applicable) address, and phone numbers. This will allow us to coordinate care if appropriate.
- ✓ Pharmacy name, address, and phone number.
- ✓ Email Address, so that you can register for an access your electronic medical record.
- ✓ If there is a language barrier, you will need to bring a translator that is 18 years of age or older that reads, writes and understands the English Language.
- ✓ If you are a minor, you will need to have an adult/guardian with you at all times.

Due to the nature and complexity of some orthopedic conditions, there could be a wait. Please know that we give each patient the same personalized attention. Your patience is appreciated. Please plan accordingly. We also advise that you read the attached sheets which include basic policies of our office. You will be asked to sign these forms. If there any are any questions they can be addressed at the office.

Driving directions to all of our office are noted on the Locations Tab of our website www.miortho.com

We look forward to providing care for you!

PATIENT INFORMATION (PLEASE PRINT)

APPT DATE:_____

Last Name, First Name, Middle:_____

Street Address, City, State, Zip :_____

Cell Phone:_____ **Home Phone**:_____

Social Security No:_____ **DOB:**_____ **Age**:_____ **Sex:** [ ] Male [ ]Female

Email:_____ **Occupation**:_____

Emergency Contact:_____ **Relationship**_____ **Phone**:_____

If Minor: Parent/Legal Guardian Name :_____ ***Cell#*** _____

Work Status: [ ] Full time [ ] Part time [ ] Homemaker [ ]Disabled [ ] Retired [ ]Unemployed [ ] Other:_____

Where do you live: [ ]Home [ ]Other:_____

Marital Status: [ ] Single [ ]Married [ ] Widowed **[ ]Divorced** **Language:** [ ]English [ ]Spanish [ ]Declined

Ethnicity: [ ]Decline [ ]Hispanic /Latino [ ]Other:_____

Race: [ ]Declined [ ]Caucasian [ ] Black [ ] Asian [ ] Native American

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How did you hear about us? [ ]Physician [ ]Internet [ ]Friend/Family [ ]Hospital/ED [ ]Other:_____

Referring Physician:_____ City: _____Phone:_____

Primary Care Physician: _____City: _____Phone:_____

Cardiology Physician: _____City: _____Phone:_____

Name of Primary Insurance:_____ **Employer**:_____

Subscriber Name:_____ **Subscriber SS No**:_____

Subscriber DOB:_____ **Group #**:_____ **Policy #**:_____

Patient Relationship to the subscriber: [ ]**Self** [ ]**Spouse** [ ] **Child** [ ]**Other:**_____

Name of Secondary Insurance:_____ **Employer**:_____

Subscriber Name: _____ **Subscriber SS No**:_____

Subscriber DOB: _____ **Group #**:_____ **Policy #**:_____

Patient Relationship to the subscriber: [ ]**Self** [ ]**Spouse** [ ]**Child** [ ] **Other:**_____

Last Name, First Name, Middle:_____ **DOB:**_____

Auto/Workers Comp/Other Carrier

DO YOU HAVE AN INJURY? [ ]YES [ ]NO DATE OF INJURY:_____/_____/_____

Do you have an open claim? MUST COMPLETE BELOW

Auto: [ ]Yes [ ]No **Workers Comp: [ ]Yes [ ]No** **Other Liability: [ ]Yes [ ]No**

Claim #:_____ **Treated in the Emergency Room? [ ] Yes [ ]No Which One:**_____

Body Part Injured:_____ **If Applicable: [ ] Right or [ ] Left**

Current Work Restrictions: [ ] Regular [ ] Light Duty [ ] Not working due to Injury [ ] Disabled

Are you currently receiving or do you plan to apply for: **[ ] Disability [ ]Workers Comp [ ] Unemployment**

Last Date worked at your regular job? _____

Insured Name:_____
Last Name, First Name, Middle

Do you have coordination of benefits: **[ ]** Yes **[ ]**No **Is your regular health insurance primary**: **[ ]**Yes **[ ]**No

Carrier Name	Address:	Phone:
Adjuster Name:	Email:	Phone:
Case Manager Name:	Email:	Phone:

AUTHORIZATION FOR TREATMENT &PAYMENT

The above information is true to the best of my knowledge. I hereby authorize treatment of the above named person and acknowledge to that I am able to read, write and understand English and if not, I have brought an adult with me who is able to interpret on my behalf. I authorize my doctor's billing pc, Michigan Orthopedic Specialists and it's agents to furnish information to my current or future insurance carrier(s) any information needed for the purposes of securing payment for services provided and assign all payment for services provided to the treating physician. I u n d e r s t a n d that I am financially responsible for any amounts not covered by my insurance and any co-pay, co-insurance, balance or deductible will be collected before I am treated by the physician. Any amounts owing after my insurance has paid their portion will be remitted p r o m p t l y upon receipt of a statement. It is my responsibility to obtain any authorization required prior to seeing the specialist and I may not be seen without it if required due to insurance.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

ACKOWLEDGEMENT OF FINANCIAL POLICY

By signing below I acknowledge that I have reviewed a copy of this office's Financial Policy which is available at the office or on the website www.miortho.com.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

PATIENT NAME:_____ **DOB**:_____

Height:_____ Weight:_____

What body part is involved?_____ ☐ right ☐ left

What is the main reason for this visit? ☐ pain ☐ numbness ☐ weakness ☐ swelling ☐ stiffness

☐ other_____ When did it start?_____(date)

☐ If Injury, please explain_____

Have you had a problem like this before? ☐ yes ☐ no If yes, when: _____

On a scale of 1-10 (10 is the worst), How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10 (circle)

What is the quality of the pain? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning

The pain is: ☐ constant ☐ comes and goes Does your pain wake you from sleep? ☐ yes ☐ no

Do you have ☐ swelling ☐ bruising ☐ numbness ☐ tingling ☐ weakness ☐ loss of bowel/bladder

Since my problem started, it is ☐ getting better ☐ getting worse ☐ unchanged

What makes your symptoms worse? ☐ standing ☐ walking ☐ squatting ☐ exercising ☐ twisting

☐ sitting ☐ stairs ☐ lifting ☐ kneeling ☐ bending ☐ coughing ☐ sneezing ☐ lying in bed

What makes your symptoms **better**? ☐ rest ☐ elevation ☐ ice ☐ heat ☐ other _____

Have you had any of these treatments? Injection: ☐ yes ☐ no brace: ☐ yes ☐ no

physical therapy: ☐ yes ☐ no cane/crutch: ☐ yes ☐ no

What tests have you had for this problem? ☐ x-rays ☐ MRI ☐ CT scan ☐ bone scan ☐ EMG Have you had surgery for a problem in the same area either recently or in the past? ☐yes ☐no

If yes, previous surgery and date: _____

Current work status: ☐ regular ☐ light duty (how long?_____) ☐ not working due to this problem

☐ disabled ☐ retired ☐ student

When is the last date you worked your regular job? _____

Are you currently receiving or do you plan to apply for: disability ☐ yes ☐ no

workers' comp ☐ yes ☐ no unemployment ☐ yes ☐no

Patient Name:_____**DOB:**_____

Pharmacy: _____ **City:** _____**Phone:**_____

Allergies	Reactions

Medications	Dosage

For additional Medications please provide list

Please complete the attached OMR Form (Bubble Sheet)

DR. MILIA'S PAIN MEDICATION POLICY

No prescription Narcotics will be dispensed until after you have been evaluated, deemed a surgical candidate, and surgery has been scheduled. All medication refills must be called in to the refill line within 72 hours of running out.

If you have had surgery by Dr. Milia, pain medication will be prescribed for a maximum of 2 months after surgery. Your primary care physician is responsible for any pain management after that point. All prescriptions will be for a 7 day supply or less.

When receiving pain medications by Dr. Milia, you must disclose any other sources from which you are receiving pain medications. Random pharmacy database checks will be made, and if you are receiving pain medications from multiple doctors, your pain medication will be terminated.
Your medication is your responsibility; if lost or stolen, it will not be refilled until the appropriate date.

DR. MILIA'S DISABILITY POLICY

No work notes will be filled out unless you have been evaluated, deemed a surgical candidate, and surgery has been scheduled. NO PERMANENT DISABILITY WILL BE GIVEN TO ANY PATIENT.

Patient Signature:_____ **Date:**_____