KAMIL ORTHOPAEDIC GROUP

6621 W. Maple Road
West Bloomfield, Mi. 48322
Phone (248) 661-4700
www.kamilorthopaedic.com

PATIENT INFORMATION (Fill in, print, and bring to your appointment)

First Name:____________________ Middle Initial:__________ Last Name:____________________

Sex: ○ Male ○ Female SSN#:____________________ Date of Birth:____________________

Address:______________________________ City:__________ State:_____ Zip:_______

Home Phone:______________ Work Phone______________ Cell Phone:______________

Email Address:______________@______________ Prefers to be called:______________

SPOUSES INFORMATION

First Name:______________ Last Name:____________________ Date of Birth:__________

Work Phone:__________ Emergency Contact Person: ○ Same as Spouse ○ Other ______________ Phone:__________ Relationship:__________

WHO REFERRED YOU TO THE OFFICE

Dr. Name:______________ Phone:______________ Hospital:______________
Other:____

RESPONSIBLE PARTY INFORMATION (PERSON'S NAME WHO APPEARS ON YOUR INSURANCE CARD)

Note*: If your name is not the primary name on the insurance card, you are NOT the responsible party*

Name On Card:____________________ Date of Birth:__________ SSN#:______________

Address:______________________________ City:__________ State:_____ Zip:_______

Employer Name:______________ Work Phone:______________ Relationship:______________

Attention Parents: It is the policy of this office that the parent who requests treatment for his/her child is responsible for all fees for service

INSURANCE INFORMATION

Primary Insurance:

○ Blue Cross Blue Shield
○ Medicaid
○ Auto Owners
○ Medicare
○ Workers' Comp
○ Other______________

Secondary Insurance:

○ Blue Cross Blue Shield
○ Medicaid
○ Auto Owners
○ Medicare
○ Workers' Comp
○ Other______________

I authorize the release of any medical information necessary to process my insurance or disability claims, and I authorize payment of medical benefits to be made to the physician for services rendered. I understand that if I am covered under an HMO policy that a referral is necessary for **every** visit and that it is my responsibility to provide the referral at the time of the visit. I agree to pay my copays, deductibles, and any balance that is denied or in dispute by my insurance company. This authorization is valid unless or until revoked in writing by the person that holds that privilege.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT ON PRIVACY PAGE OF THIS WEBSITE I acknowledge that I have been offered a copy of Kamil Orthopaedic Group's Notice of Privacy Practices

I Authorize the Following People to Discuss my Medical Information (Please provide Names and Relationship):

____

____

Signature:______________________________ **Date:**______________
(Patient, Parent, or Responsible Party – sign after printing)

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PATIENT HEALTH INFORMATION

First Name:______________________ Middle Initial:______ Last Name:______________________

Height:________ft.________in. Weight:__________lbs. BP:______/______ Temperature:__________°F

CURRENT PROBLEM / REASON FOR VISIT TO OFFICE

Current Problem:______________________________________ Date it Started:______________

Is this from an auto accident? ○ Yes ○ No or Work related injury / problem? ○ Yes ○ No

Any test done? (list test names):______________________________________

What has been done to improve this problem? ______________________________________

PAST MEDICAL HISTORY

Please check all that apply:

○ High Blood Pressure	○ Heart Disease	○ Asthma	○ Diabetes	○ Gout
○ Arthritis	○ Psoriasis	○ Stroke	○ Parkinson's	○ Hepatitis
○ HIV / AIDS	○ Lupus	○ Seizures	○ Reflux (GERD)	○ Ulcers
○ Depression	○ Thyroid Disease	○ High Cholesterol	○ Hiatal Hernia	○ Rheumatoid Arthritis
○ Osteoporosis	○ Cancer – Type:______________________			

Medication List:______________________________________
____

Drug Allergies? (list):______________________________________

Osteoporosis Screening

○ Post-Menopausal ○ Hysterectomy ○ Height Loss ○ Stress Fracture ○ Previous Bone Density

○ Age Greater then 70 Last Done? (list test name and date):______________________

PAST SURGICAL HISTORY

____
____

SOCIAL HISTORY

Employment Status: ○ Full-Time ○ Part-Time ○ Retired ○ Student ○ Not Employed Occupation:______________

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced

How many children? ______________

Do you drink Alcohol? ○ Yes ○ No How many drinks per week? ___ Do you smoke? ○ Yes ○ No How many packs per week? ___

Exercise Regimen:______________________________________