Committed to Excellence in Orthopedics
OSOC
Orthopedic Specialists of Oakland County

WWW.OSOC.COM

248-335-2977

PATIENT INFORMATION

PATIENT NAME _____
FIRST MI LAST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

HOME PHONE: _____ E-MAIL : _____

WORK PHONE: _____ MOBILE: _____

RACE _____ ETHNICITY _____ PREFERRED LANGUAGE _____

EMERGENCY NUMBER: (A FRIEND, NEIGHBOR, OR RELATIVE OTHER THAN A HOME NUMBER): _____

BIRTH DATE: _____ ☐ MALE ☐ FEMALE

HEIGHT _____ WEIGHT _____ lbs MARITAL STATUS: ☐M ☐S ☐ D ☐ W

PATIENTS SOCIAL SECURITY NUMBER _____

WHO WERE YOU REFERRED BY? _____

WHAT IS THE REASON FOR THE APPOINTMENT _____

WHAT KIND OF INSURANCE DO YOU HAVE? _____

IS YOUR PROBLEM RELATED TO AN INJURY? ☐ Y OR ☐ N

WAS THIS AN AUTO ACCIDENT? ☐ Y OR ☐ N DATE OF INJURY: _____

WAS THIS AN ON THE JOB INJURY? ☐ Y OR ☐ N DATE OF INJURY: _____

PARTY RESPONSIBLE FOR BILL: _____

**INSURANCE INFORMATION (SUBSCRIBER IS THE PERSON WHOSE EMPLOYER IS PROVIDING THE INSURANCE)

SUBSCRIBERS NAME: _____ SUBSCRIBERS DOB: _____

SUBSCRIBERS ADDRESS IF DIFFERENT THAN PATIENT: _____

EMPLOYER: _____ WORK PHONE NUMBER: _____

EMPLOYERS ADDRESS: _____

1.) I HEREBY AUTHORIZE OSOC, TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN. THIS INFORMATION MAY BE SENT BY U.S. MAIL OR FAX MACHINE.

2.) I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DRS KASSAB OR BAHU FOR ALL SERVICES RENDERED.

3.) I UNDERSTAND THAT IF OUR PRACTICE IS NOT A PARTICIPATING PROVIDER FOR MY INSURANCE, THAT I AM RESPONSIBLE FOR THE REMAINING AMOUNT UNPAID BY MY INSURANCE.

X_____DATE:_____

** IF YOUR COMMERCIAL OR THIRD PARTY INSURANCE DOES NOT PAY THE BILLING AMOUNT IN FULL, THE BALANCE WILL BE YOUR RESPONSIBILITY.

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NAME:

ARE YOU UNDER A PHYSICIAN'S CARE? ☐Y OR ☐N FOR WHAT CONDITION?

PHYSICIANS NAME AND ADDRESS:

LIST ANY SURGERIES:

REASONS FOR ANY HOSPITALIZATIONS IN THE PAST 5 YEARS:

DO YOU SMOKE? ☐N OR ☐ Y ☐*CIGARS* ☐*CIGARETTES* PACKS PER DAY: NO. OF YEARS:

DO YOU DRINK ALCOHOL? ☐N OR ☐ Y ☐*RARE* ☐*OCCASIONAL* ☐*DAILY*

DO YOU HAVE ANY OF THE FOLLOWING: ☐ NONE

☐	RHEUMATIC FEVER	☐	EPILEPSY
☐	JAUNDICE	☐	HEART ATTACK
☐	INFLAMMATORY RHEUMATISM	☐	STROKE
☐	HEPATITIS	☐	STOMACH ULCER
☐	DIABETES	☐	ASTHMA / HAY FEVER
☐	HIGH BLOOD PRESSURE	☐	HIVES OR SKIN RASH
☐	ANEMIA	☐	KIDNEY PROBLEM
☐	ARTHRITIS	☐	

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING: ☐ NONE

	CANCER	Diabetes	Heart Problems	OTHER:
MOTHER ☐ ALIVE ☐ DECEASED	☐	☐	☐	
FATHER ☐ ALIVE ☐ DECEASED	☐	☐	☐	

LIST ANY / ALL MEDICATION(S) OR DRUG(S) YOU MAY BE TAKING:

MEDICATION	DOSE / FREQUENCY	MEDICATION	DOSE / FREQUENCY
.1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING:

☐ NONE	☐ Penicillin	☐ Sulfa	☐ Antibiotics
☐ Codeine	☐ Aspirin	☐ Iodine	☐ Cortisone
☐ Local Anesthesia	☐ Others:		

DO YOU HAVE ANY OTHER DISEASE, CONDITION, OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT? PLEASE EXPLAIN:

PRINT NAME SIGNATURE OF PATIENT OR GUARDIAN OF PATIENT DATE

Online 2/19/2018

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Rx Policy

Our office has changed to electronic prescriptions. To better accommodate you, our office would like to obtain some additional information. Please help us update your file.

Patient Name:

DOB:

PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Number: Fax:

Address:

Primary Care Physician's Name:

Primary Care Physician's Number:

Primary Care Physician's Fax:

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We look forward to serving all your orthopedic needs in one of our offices:

BLOOMFIELD OFFICE	CLARKSTON OFFICE
44038 WOODWARD AVE. STE 200 BLOOMFIELD, MI. 48302 PHONE: 248 -335 - 2977	7650 DIXIE HWY STE 100 CLARKSTON, MI. 48346 PHONE: 248 -335 - 2977

Please be sure you bring the following:

- **photo ID and insurance card(s)**
- **the attached forms, filled out**
- **ANY X-RAYS TAKEN OF THE PROBLEM AREA**
- **any medical reports or test results pertaining to your problem**
- **current list of medications with strength and dosage**

****IF YOU HAVE AN HMO INSURANCE: you must make sure a referral gets to our office before your appointment. Without a referral, we will have to reschedule. We suggest you give our office a call 1 to 2 days prior to your appointment to verify that your referral has been sent and that it gives authorization for the office visit and the proper procedures.**

**** IF YOUR INJURY IS WORK OR AUTO RELATED: you must have authorization from the insurance company sent to our office prior to appointment. Without an open claim letter, we will have to reschedule your appointment.**

We look forward to taking care of your orthopedic needs. If you should have any additional questions, please do not hesitate to call our office.

Thank You.