

## General Consent to Treat

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means: \_\_\_\_\_ (name of patient).

I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent. \_\_\_\_\_ (Please initial)

### Sharing Records for Treatment

We share medical records electronically and in paper form with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical system, they may have access to your medical record.

### Voicemail and Text Notifications

As a service to our patients, Orthopaedic Associates of Muskegon or West Michigan Spine Center provides courtesy appointment reminder calls/texts and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below, you consent to receiving such calls/texts at the cell phone number you have provided to us. \_\_\_\_\_ (Please initial)

### Electronic Prescriptions (E-Prescribing)

I voluntarily authorize Orthopaedic Associates of Muskegon or West Michigan Spine Center to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a physician/patient relationship exists, or until I withdraw my consent. \_\_\_\_\_ (Please initial)

### Acknowledgment: Notice of Privacy Practices

I acknowledge receiving/reviewing Orthopaedic Associates of Muskegon or West Michigan Spine Center or Grand Haven Bone and Joint Notice of Privacy Practices ("Notice"). The Notice explains how Orthopaedic Associates of Muskegon or West Michigan Spine Center or Grand Haven Bone and Joint may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. **If you have questions about the Notice, please contact Orthopaedic Associates of Muskegon or West Michigan Spine Center Privacy Office or Grand Haven Bone and Joint at (231)733-1326.** \_\_\_\_\_ (Please initial)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Patient's Name: \_\_\_\_\_ Date of birth (MM/DD/YYYY): \_\_\_\_\_

Name of Patient's Representative, if patient under 18: \_\_\_\_\_

Signature of Patient or Patient's Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**ABOVE - PATIENT OR PERSONAL REPRESENTATIVE USE ONLY**

**BELOW - OAM USE ONLY**

### Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

- Patient refused to sign the Privacy Notice Acknowledgement
- Patient was unable to sign because:
- Other reason, described below:

Medical Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorizations and Permissions

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I request payment of claims from BCBSM, Medicare, Medicaid, Worker's Compensation, Auto or Commercial insurance be made for me or on my behalf to Orthopaedic Associates of Muskegon PC for any services or supplies furnished to me. I understand the provider's charge may exceed the insurance payment, and if greater than such payment, I will be responsible for the balance.

I authorize any holder of medical information to release my health care financial and medical information in order to determine payment for related services, or for coordination of care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize the release of my medical information to the following person(s):

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient's Maiden Name: \_\_\_\_\_ Seen Before In Office By Dr: \_\_\_\_\_

If Child, Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Responsible Party's Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Current Problem: \_\_\_\_\_ Date Of Onset: \_\_\_\_\_

Is This Work Or Auto Related?: \_\_\_\_\_ Where Did Injury Occur?: \_\_\_\_\_ Date: \_\_\_\_\_

Have You Been Treated For This Condition Before?: \_\_\_\_\_ By Whom?: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature of Patient or Patient's Representative: \_\_\_\_\_ Date: \_\_\_\_\_



# System Review and Past Medical History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

From the following list, please check any symptoms or conditions that apply to you:

- |   |   |   |   |
|---|---|---|---|
| <p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rashes, psoriasis or dermatitis</li> <li><input type="checkbox"/> History of skin cancer</li> <li><input type="checkbox"/> New skin growth or mole</li> </ul> <p><b>EYES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Wear glasses</li> <li><input type="checkbox"/> Wear contact lenses</li> <li><input type="checkbox"/> Permanent blindness in either eye</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Glaucoma</li> </ul> <p><b>EARS/NOSE/THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Hearing aids? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li><input type="checkbox"/> Ringing in the ears</li> <li><input type="checkbox"/> Frequent ear aches</li> <li><input type="checkbox"/> Discharge from the ear</li> <li><input type="checkbox"/> Attacks of vertigo</li> <li><input type="checkbox"/> Frequent sinus infections</li> <li><input type="checkbox"/> Nasal blockage</li> <li><input type="checkbox"/> Frequent sneezing</li> <li><input type="checkbox"/> Frequent sore throat</li> <li><input type="checkbox"/> Exposure to loud noise</li> <li><input type="checkbox"/> Loud snoring</li> <li><input type="checkbox"/> Recent change in voice quality</li> <li><input type="checkbox"/> Sleep apnea</li> <li><input type="checkbox"/> Difficulty in swallowing</li> <li><input type="checkbox"/> Frequent headache</li> <li><input type="checkbox"/> Nose bleeds</li> </ul> <p><b>ENDOCRIN/METABOLISM</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Thyroid disorder</li> <li><input type="checkbox"/> Recent weight gain or loss (more than 10 lbs)</li> <li><input type="checkbox"/> Diabetes</li> </ul> | <p><b>RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Asthma or wheezing Yes No</li> <li><input type="checkbox"/> Recent bronchitis or chest cold</li> <li><input type="checkbox"/> Cough for over the past 2 months</li> <li><input type="checkbox"/> Coughing up blood</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Sinus trouble</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> COPD/Emphysema</li> </ul> <p><b>HEART &amp; CIRCULATION</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Heart attack</li> <li><input type="checkbox"/> Scarlet fever</li> <li><input type="checkbox"/> Heart murmur</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Chest discomfort (angina) with activity</li> <li><input type="checkbox"/> Heart failure or fluid on the lungs</li> <li><input type="checkbox"/> Palpitations, racing or pounding heart beat</li> <li><input type="checkbox"/> Mitral valve prolapsed</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Blood clot in artery or vein</li> <li><input type="checkbox"/> "Mini strokes" or TIAs</li> <li><input type="checkbox"/> "Black out spells"</li> <li><input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Aneurysm of any blood vessel</li> <li><input type="checkbox"/> Frequent ankle swelling at bedtime</li> <li><input type="checkbox"/> Heart surgery</li> <li><input type="checkbox"/> Congenital heart problems</li> <li><input type="checkbox"/> Hypertension (high blood pressure)</li> </ul> | <p><b>STOMACH/INTESTINES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stomach ulcer or peptic ulcer</li> <li><input type="checkbox"/> Hiatal hernia and or acid reflux</li> <li><input type="checkbox"/> Poor appetite</li> <li><input type="checkbox"/> Gallbladder attacks</li> <li><input type="checkbox"/> Frequent diarrhea</li> <li><input type="checkbox"/> Frequent heartburn or indigestion</li> <li><input type="checkbox"/> Chronic constipation</li> <li><input type="checkbox"/> Bright blood from bowels or rectum</li> <li><input type="checkbox"/> Dark, tarry stools</li> <li><input type="checkbox"/> Liver disease or jaundice</li> <li><input type="checkbox"/> Hernia</li> </ul> <p><b>KIDNEYS/URINARY TRACT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney disease or failure</li> <li><input type="checkbox"/> History of kidney dialysis</li> <li><input type="checkbox"/> Kidney stones or infection</li> <li><input type="checkbox"/> Pain or burning with urination</li> <li><input type="checkbox"/> Trouble starting urinary stream</li> <li><input type="checkbox"/> Dribbling or incontinence</li> <li><input type="checkbox"/> Multiple trips to the bathroom to urinate at night</li> <li><input type="checkbox"/> Bladder infections during past year</li> <li><input type="checkbox"/> Blood in urine past year</li> <li><input type="checkbox"/> Prostate disease</li> </ul> <p><b>MUSCLES/BONES/JOINTS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arthritis or other joint disease</li> <li><input type="checkbox"/> Chronic back trouble</li> <li><input type="checkbox"/> Bone or joint surgery in past year</li> <li><input type="checkbox"/> Fibromyalgia</li> </ul> | <p><b>NERVOUS SYSTEM</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Migraine headaches</li> <li><input type="checkbox"/> Anorexia</li> <li><input type="checkbox"/> Multiple sclerosis</li> <li><input type="checkbox"/> Psychiatric care</li> <li><input type="checkbox"/> Epilepsy or seizures<br/>Date of last seizure: _____</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Other nervous disorder<br/>Specify: _____</li> </ul> <p><b>BLOOD</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding or bruising tendency</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Previous blood transfusion</li> <li><input type="checkbox"/> Circulatory problems</li> <li><input type="checkbox"/> History of hepatitis</li> </ul> <p><b>REPRODUCTIVE (WOMEN ONLY)</b></p> <p>Are you or might you be pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>MISC</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Drug/alcohol dependency</li> <li><input type="checkbox"/> Chicken pox</li> <li><input type="checkbox"/> Herpes</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> Latex allergy</li> <li><input type="checkbox"/> Measles</li> <li><input type="checkbox"/> Mumps</li> <li><input type="checkbox"/> Polio</li> <li><input type="checkbox"/> Venereal Disease</li> </ul> |
|---|---|---|---|

Please indicate the following diseases if your family members (blood relatives) have experienced them:  
 Diabetes  Cancer  High Blood Pressure  Allergy  Hearing Loss  Stroke  Bleeding Disorder

List any other illness that "runs in your family" (blood relatives): \_\_\_\_\_

Do you have any other special concerns or additional information that we should be aware of regarding your care? \_\_\_\_\_

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SOAPP®-R

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Please answer each question as honestly as possible. There is no right or wrong answer.**

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How often have you felt impatient with your doctors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often is there tension in the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often do you feel bored?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How often have you worried about being left alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. How often have you felt a craving for medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. How often have others expressed concern over your use of medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. How often have others told you that you had a bad temper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. How often have you run out of pain medication early?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. How often have others kept you from getting what you deserve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. How often have you attended an AA or NA meeting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. How often have you been sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>