Orthopaedic Associates of Muskegon
West Michigan Spine Center
Grand Haven Bone & Joint
www.oamkg.com
www.wmspinecenter.com
www.ghboneandjoint.com
☐ 1400 Mercy Dr., Suite 100, Muskegon MI 49444 **231-733-1326**
☐ 1445 Sheldon Rd., Suite G1, Grand Haven MI 49417 **616-296-9100**

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: _____

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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: _____

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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:_____

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System Review and Past Medical History

Name: _____ DOB: _____

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

SKIN
- ☐ Rashes, psoriasis or dermatitis
- ☐ History of skin cancer
- ☐ New skin growth or mole

EYES
- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Permanent blindness in either eye
- ☐ Cataracts
- ☐ Glaucoma

EARS/NOSE/THROAT
- ☐ Loss of hearing
- ☐ Hearing aids? ☐ Yes ☐ No
- ☐ Ringing in the ears
- ☐ Frequent ear aches
- ☐ Discharge from the ear
- ☐ Attacks of vertigo
- ☐ Frequent sinus infections
- ☐ Nasal blockage
- ☐ Frequent sneezing
- ☐ Frequent sore throat
- ☐ Exposure to loud noise
- ☐ Loud snoring
- ☐ Recent change in voice quality
- ☐ Sleep apnea
- ☐ Difficulty in swallowing
- ☐ Frequent headache
- ☐ Nose bleeds

ENDOCRIN/METABOLISM
- ☐ Thyroid disorder
- ☐ Recent weight gain or loss (more than 10 lbs)
- ☐ Diabetes

RESPIRATORY
- ☐ Tuberculosis
- ☐ Asthma or wheezing Yes No
- ☐ Recent bronchitis or chest cold
- ☐ Cough for over the past 2 months
- ☐ Coughing up blood
- ☐ Pneumonia
- ☐ Sinus trouble
- ☐ Shortness of breath
- ☐ COPD/Emphysema

HEART & CIRCULATION
- ☐ Heart attack
- ☐ Scarlet fever
- ☐ Heart murmur
- ☐ Low blood pressure
- ☐ Chest discomfort (angina) with activity
- ☐ Heart failure or fluid on the lungs
- ☐ Palpitations, racing or pounding heart beat
- ☐ Mitral valve prolapsed
- ☐ Stroke
- ☐ Blood clot in artery or vein
- ☐ "Mini strokes" or TIAs
- ☐ "Black out spells"
- ☐ Pacemaker
- ☐ Shortness of breath
- ☐ Aneurysm of any blood vessel
- ☐ Frequent ankle swelling at bedtime
- ☐ Heart surgery
- ☐ Congenital heart problems
- ☐ Hypertension (high blood pressure)

STOMACH/INTESTINES
- ☐ Stomach ulcer or peptic ulcer
- ☐ Hiatal hernia and or acid reflux
- ☐ Poor appetite
- ☐ Gallbladder attacks
- ☐ Frequent diarrhea
- ☐ Frequent heartburn or indigestion
- ☐ Chronic constipation
- ☐ Bright blood from bowels or rectum
- ☐ Dark, tarry stools
- ☐ Liver disease or jaundice
- ☐ Hernia

KIDNEYS/URINARY TRACT
- ☐ Kidney disease or failure
- ☐ History of kidney dialysis
- ☐ Kidney stones or infection
- ☐ Pain or burning with urination
- ☐ rouble starting urinary stream
- ☐ Dribbling or incontinence
- ☐ Multiple trips to the bathroom to urinate at night
- ☐ Bladder infections during past year
- ☐ Blood in urine past year
- ☐ Prostate disease

MUSCLES/BONES/JOINTS
- ☐ Arthritis or other joint disease
- ☐ Chronic back trouble
- ☐ Bone or joint surgery in past year
- ☐ Fibromyalgia

NERVOUS SYSTEM
- ☐ Migraine headaches
- ☐ Anorexia
- ☐ Multiple sclerosis
- ☐ Psychiatric care
- ☐ Epilepsy or seizures
  Date of last seizure: _____
- ☐ Depression
- ☐ Other nervous disorder
  Specify: _____

BLOOD
- ☐ Bleeding or bruising tendency
- ☐ Anemia
- ☐ Previous blood transfusion
- ☐ Circulatory problems
- ☐ History of hepatitis

REPRODUCTIVE (WOMEN ONLY)
Are you or might you be pregnant?
☐ Yes ☐ No

MISC
- ☐ Cancer
- ☐ Drug/alcohol dependency
- ☐ Chicken pox
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Latex allergy
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Venereal Disease

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: _____