Michigan Street Orthopedic Specialists, P.C.

Patient Registration Form

PATIENT INFORMATION

Date: ____________________

Legal Name: ______________________________ How do you prefer to be addressed? ____________

Address: ____

Street City State Zip code

Home Phone # ______________ Work Phone #: ____________ Cell / Pager: ____________

Date of Birth: ____________ Age: ________ Height: ________ Weight: ________ Sex: ______

Driver's License # : ________________ Social Security # : ________________

Marital Status: Single, Married, Divorced, Widowed (circle one) Right handed or Left handed (circle one)

Smoker or Non Smoker (circle one) If you are a Smoker, how many packs per day? ________

GUARANTOR INFORMATION

(Responsible party)

Guarantor Name: ______________________________ Relationship to Patient: ____________

Guarantor Address: ____

Street City State Zip code

Home Phone # ______________ Work Phone #: ____________ Cell phone / Pager #: ____________

MEDICAL HISTORY

Did you have an accident / injury? (Yes or No) ____________ Date of accident / injury: ____________

What were you doing when you injured yourself? ______________________________

What body part(s) are you being seen for today? ______________________________

What symptoms are you experiencing? ______________________________

Approximately, how long have you had these symptoms? ______________________________

Previous Surgeries & Other Medical Problem(s): ______________________________

____

WHAT TESTS HAVE BEEN COMPLETED REGARDING TODAYS VISIT

(X-ray, MRI, CT Scan, Bone Scan, EMG Study)

Test(s)	Date of Service	Name of Facility	Did you bring today?

Primary Care Physician

Physicians name: ______________________________

Address: ______________________________

City, St. Zip ______________________________

Phone #: ______________________________

Referring Physician

Physicians name: ______________________________

Address: ______________________________

City, St. Zip ______________________________

Phone #: ______________________________

Have you ever been diagnosed with the following?

	Yes	No
Anemia	☐	☐
Asthma	☐	☐
Bleeding Problems	☐	☐
Cancer	☐	☐
Claustrophobic	☐	☐
Diabetes	☐	☐
Elevated Cholesterol	☐	☐
Heart Problems	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
Latex Allergy	☐	☐
Metal Implant	☐	☐
Reaction to Anesthesia	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Other		

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EMPLOYER INFORMATION Are you employed? Yes: _____ No: _____ Are you retired? Yes: _____ No: _____

Employer Name: ______________________ Phone number: ______________

Employer Address: ____

Street City State Zip code

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ______________________ Relationship: ______________

Home Phone # ______________ Work Phone #: ______________ Cell phone / Pager: ______________

HEALTH INSURANCE INFORMATION **Please present your Insurance Card(s)** (only if today's visit applies)

(NOTE: You must provide policy holder name, DOB, & SSN for each policy or the claim will be denied by your insurance).

1.) Primary Ins: ______________ Policy Holder Name: ______________

Policy Holder SSN: ______________ Policy Holder Date of Birth: ______________

2.) Secondary Ins: ______________ Policy Holder Name: ______________

Policy Holder SSN: ______________ Policy Holder Date of Birth: ______________

3.) Third Ins: ______________ Policy Holder Name: ______________

Policy Holder SSN: ______________ Policy Holder Date of Birth: ______________

AUTO ACCIDENT INFORMATION (Only fill out this section if today's visit applies to an Auto accident)

Auto Insurance Co. Name: ______________________ Date of Accident: ______________

Auto Insurance Co. Address: ____

Street City State Zip code

Name of Policy Holder: ______________________ Claim Number: ______________

Claim Representative: ______________________ Phone Number: ______________

WORK COMP INFORMATION (Only fill out this section if today's visit applies to a Work Comp accident/injury)

Employer: ______________ Address: ______________________
(at the time of injury)

Employer Phone: ______________ Contact Person: ______________ Date of Injury: ______________

Claim #: ______________ Is the claim in dispute? ______ Was Claim filed with Employer:? ______

Worker's Comp - Insurance Company: ____

Address: ____

Street City State Zip code

Contact Person: ______________________ Phone: ______________ Ext: ______