HEALTH HISTORY FORM

PLEASE PRINT CLEARLY

PATIENT DEMOGRAPHICS

TODAY'S DATE ____________

PATIENT NAME: (LAST) ______________________ (FIRST) ______________________ (MI) ________

DATE OF BIRTH: ____________ AGE: ______ SEX: ☐ Male ☐ Female MARITAL STATUS: ☐ Single ☐ Married

SOCIAL SECURITY NUMBER: ____________________

ADDRESS: ____

CITY: ______________________________ STATE: ______________ ZIP: ____________

MAILING ADDRESS (IF DIFFERENT FROM ABOVE): ______________________________

CITY: ______________________________ STATE: ______________ ZIP: ____________

HOME PHONE: (_____) ______________ WORK PHONE: (_____) ______________ CELL PHONE: (_____) ______________

EMPLOYER: ______________________ OCCUPATION: ______________________

EMPLOYER'S ADDRESS: ______________________________________

CITY: ______________________________ STATE: ______________ ZIP: ____________

SPOUSE'S NAME: (LAST) ______________________ (FIRST) ______________________ (MI) ________

SPOUSE'S EMPLOYER: ______________ WORK PHONE: (_____) ______________ CELL PHONE: (_____) ______________

PLEASE GIVE US AN ALTERNATE CONTACT OTHER THAN YOUR HOME PHONE

EMERGENCY CONTACT: (LAST) ______________________ (FIRST) ______________________ (MI) ________

RELATIONSHIP TO PATIENT: ______________ PHONE: ☐ Cell ☐ Home ☐ Work NUMBER: (_____) ______________

COMPLETE THIS SECTION IF PATIENT IS A MINOR (UNDER 18)

PERSON RESPONSIBLE FOR CHARGES (Adult that accompanies minor at time of office visit)

NAME: (LAST) ______________________ (FIRST) ______________________ (MI) ________

RELATIONSHIP TO PATIENT: ☐ Mother ☐ Father ☐ Grandparent ☐ Other ______________________

SOCIAL SECURITY NUMBER: ______________ DATE OF BIRTH: ______________ EMPLOYER: ______________

ADDRESS (IF DIFFERENT FROM PATIENT): ______________________________

CITY: ______________________________ STATE: ______________ ZIP: ____________

HOME PHONE: (_____) ______________ WORK PHONE: (_____) ______________ CELL PHONE: (_____) ______________

SPORTS ORTHOPEDIC SPECIALIST
JOSEPH YACISEN, D.O.
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PHONE: 989.466.2663 • FAX: 989.466.4748

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TODAY'S DATE ____________

PATIENT NAME: (LAST) ________________________________ (FIRST) ____________________________ (MI) __________

INSURANCE INFORMATION (THIS INFORMATION CAN BE FOUND ON YOU ID CARD)

PRIMARY INSURANCE NAME:__________________________CUSTOMER SERVICE PHONE NUMBER: (____) ______________

BILLING ADDRESS:____

CITY: ____STATE:__________________ZIP: ____________

IDENTIFICATION #: ____ GROUP #:________________________________

POLICY HOLDER: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ______________

POLICY HOLDER'S NAME: ____ DATE OF BIRTH_________________

SECONDARY INSURANCE NAME: _______________________CUSTOMER SERVICE PHONE NUMBER: (____) ______________

BILLING ADDRESS:____

CITY: ____STATE:__________________ZIP: ____________

INDENTIFICATION #:____ GROUP #:________________________________

POLICY HOLDER: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ______________

POLICY HOLDER'S NAME: ____ DATE OF BIRTH_________________

CONSENT FOR MEDICAL TREATMENT

I hereby authorize any treatment(s), agreed upon with the physicians, which may be deemed advisable.

OFFICE PRESCRIPTION POLICY

Our office requests a 24-hour notice to refill any medication(s) on weekdays. Medications requested on Friday after 1pm, as well as Saturday and Sunday, will not be refilled until Monday afternoon or Tuesday morning. It is our clinic policy that no medications will be refilled after office hours.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions. I authorize the release of my medical records to my Referring and Primary Care physician(s), if applicable. Additionally, I authorize____________________ , (relationship to patient: __________________), access to medical information pertaining to my treatment.

NOTICE OF PRIVARY PRACTICES

I have received a copy of the HIPPA Notice of Privacy practices for MID MICHIGAN BONE AND JOINT CENTER.

I have read and completed this form and state the information is true to the best of my knowledge and belief. I have read and fully understand the above consent for medical treatment, office prescription policy, authorization to release information, and have received a copy of the HIPPA Notice of Privacy Practices for MID MICHIGAN BONE AND JOIN CENTER.

SIGNATURE: ____ DATE:___________________

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TODAY'S DATE ____________

PATIENT NAME: (LAST) ______________________ (FIRST) ______________________ (MI) ________

MEDICAL HISTORY

REFERRED BY: ☐ Physician ☐ Emergency Room ☐ Yellow Pages ☐ Newspaper ☐ Seminar ☐ Ad ☐ Friend ☐ Insurance ☐ Attorney

☐ Other____

NAME: (LAST) ______________________ (FIRST) ______________________ (MI) ________

PRIMARY CARE PHYSICIAN (IF ANY):

NAME: (LAST) ______________________ (FIRST) ______________________ (MI) ________

REASON FOR VISIT TODAY:____

____

CURRENT PROBLEM IS THE RESULT OF A: (PLEASE CHECK THE APPROPRIATE BLOCK)

☐ Car Accident ☐ Work Accident ☐ Accident Other ______________________ ☐ Not Accident Related

DATE OF ACCIDENT: ______________ACCIDENT LOCATION ______________ STATE ________

DESCRIBE HOW YOUR INJURY OCCURED:____

____

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? ☐ Auto Insurance ☐ Employer ☐ Worker's Comp ☐ Other ________

ATTORNEY NAME AND PHONE NUMBER (IF APPLICABLE)____

CURRENT MEDICATION	DOSAGE	FREQUENCY	REASON FOR TAKING MEDICATION
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PLEASE LIST ANY ALLERGIES HERE:____

____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ Anemia
☐ Angina
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clot
☐ Cancer
☐ Chronic Back Pain
☐ Claustrophobic
☐ Congestive Heart Failure
☐ Depression
☐ Diabetes
☐ Diabetic Foot Ulcer
☐ Dialysis
☐ Emphysema
☐ GI Bleed
☐ Gout
☐ Heart Attack
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Irregular Heart Beat
☐ Kidney Failure
☐ Liver Problems
☐ Lupus
☐ Neurological Disorder
☐ Pinched Nerve
☐ Poor Circulation
☐ Prostate Problems
☐ Pulmonary Embolism
☐ Reflux
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke
☐ Tumor/Growths
☐ None (Negative)
☐ Other______________
☐ ______________
☐ ______________
☐ ______________

PLEASE ADDRESS ANY OTHER MEDICAL HISTORY CONCERNS WITH YOUR PROVIDER

CONTIUED ON NEXT PAGE

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PATIENT NAME: (LAST) ___________________________________ (FIRST) _______________________________ (MI) ___________

PAST SURGICAL HISTORY (PLEASE LIST ALL SURGERIES)

____ ____

____ ____

____ ____

____ ____

____ ____

SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY)

RISK FACTORS:

SMOKING: ☐ Self ☐ Spouse (Packs/Day)____

ALCOHOL USE: ☐ Self ☐ Spouse (Type/Amount/Day) ____

FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY)adf

DO ANY OF YOUR RELATIVES HAVE (OR DID THEY HAVE) PROBLEMS WITH ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

☐ Anesthesia Problems ☐ Bleeding Disorder ☐ Cancer ☐ Diabetes ☐ Heart Attack ☐ Osteoporosis ☐ Rheumatoid Arthritis

PATIENT SIGNATURE:____**DATE:**______________________

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BILLING DICLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CASE

There may be times when it is necessary for an individual directly involved in you care to call the facility or the Central Billing Office to inquire about your personal health information or billing information. Please a few moments to complete this form.

I AUTHORIZE MID MICHIGAN BONE AND JOINT CENTER TO DISCLOSE MY HEALTH INFORMATION THAT IS DIRECTLY REPLATED TO MY CURRENT TREATMENT AT MID MICHIGAN BONE AND JOINT CENTER TO THE INDIVIDUAL(S) LISTED BELOW FOR THE PURPOSES OF THEIR ROLE IN MY TREATMENT OR PAYMENT FOR THE HEALTH SERVICES THAT I HAVE RECEIVED.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I DO NOT WISH TO HAVE MY HEALTH INFORMATION DISCLOSED TO THE INDIVIDUALS INVOLVED IN MY CASE.

NAME	RELATIONSHIP

HOME PHONE: (_____)______________________ WORK PHONE: (_____)____________________ CELL PHONE: (_____) _______________

☐ OK to leave detailed message ☐ OK to leave detailed message ☐ OK to leave detailed message

☐ Leave call back number only ☐ Leave call back number only ☐ Leave call back number only

PATIENT SIGNATURE (or Patient's representative):____ **DATE:**________________________

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐ Power of attorney ☐ Guardian ☐ Surrogate Decision-Maker

☐ Executor of Legal Representation ☐ Parent ☐ Other (Please Specify) _________________________________

PLEASE PROVIDE DOCUMENTATION OR EXPLANATION OF YOU AUTHORITY TO ACT FOR THE PATIENT

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