

**MICHIGAN SURGERY SPECIALISTS, P.C.**  
*d/b/a's: Hand Surgery Associates of Michigan, P.C.,  
Michigan Hand & Sports Rehabilitation Centers, Life Scan Imaging of Michigan,*  
**GREATER MICHIGAN ORTHOPAEDICS & SPORTS MEDICINE**  
28001 Schoenherr Rd, Ste 3  
Warren, MI 48088  
(586) 558-9500 Fax: (586) 558-9501

**ASSIGNMENT OF BENEFITS  
MEDICAL INFORMATION AND PHOTOGRAPHY RELEASE  
PROCEDURE RELEASE**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Insurance Policy Holder Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Subscriber's Relation to Patient

I hereby authorize payment directly to **GREATER MICHIGAN ORTHOPAEDICS & SPORTS MEDICINE**, for all medical and surgical, basic, and/or medical otherwise payable to me for all treatment of the above named patient. I understand that I am financially responsible for charges to said corporation for charges not covered by my policy. I further authorize the physician to release information requested by my insurance company in order to verify and process said claim(s).

Also, by my signature I authorize **GREATER MICHIGAN ORTHOPAEDICS & SPORTS MEDICINE**, to release to the Employer, Compensation/Insurance Carrier, and/or Referring Physician any and all records or reports pertaining to the medical treatment. This will also authorize release of necessary reports to any physician to whom the patient is referred.

I am also aware that **GREATER MICHIGAN ORTHOPAEDICS & SPORTS MEDICINE** may obtain photographs of my body for medical/legal purposes. My signature authorizes use of these photographs in this manner.

I understand that for a successful Physician/Patient relationship it is important for me as a patient to return for scheduled appointments and comply with the Physician's medical instructions and otherwise cooperate with my Physician. The Physicians of **GREATER MICHIGAN ORTHOPAEDICS & SPORTS MEDICINE**, reserve the right to discontinue permanently or temporarily the Physician/Patient relationship in the event the relationship is impaired as a result of my action or inaction.

I consent to any medical, diagnostic, therapeutic, or minor surgical procedures rendered to myself under the supervision of the physician of **GREATER MICHIGAN ORTHOPAEDICS & SPORTS MEDICINE**.

**GREATER MICHIGAN ORTHOPAEDICS & SPORTS MEDICINE, A DIVISION OF MICHIGAN SURGERY SPECIALISTS, P.C.** is a privately owned full service health care delivery system which includes Oakland Regional Hospital, an acute care Hospital facility, outpatient surgical center, several physical therapy locations and diagnostic imaging services, including MRI, CT Scan, and Ultrasound. Please understand if you receive care within this system, you are choosing a facility where your treating physician may have a financial interest.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Subscriber (Parent/Guardian if Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness-Greater Michigan Orthopaedic & Sports Medicine-Employee



Are you currently under the care of a physician for a problem other than your current orthopaedic problem?  Yes  No

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone:# \_\_\_\_\_

Condition you are being treated for: \_\_\_\_\_

**SOCIAL HISTORY:**

	YES	NO	If yes please give details and or dates:
Smoker			Packs per day
Alcohol use			Amount per day

Education: Grade School \_\_\_\_\_ High School \_\_\_\_\_ College \_\_\_\_\_

Length of time at present job \_\_\_\_\_

**REVIEW OF SYSTEMS:**

	YES	NO
<b>EYES</b>		
Have you noticed any recent change in your vision		
<b>SKIN</b>		
Do you have any rashes at the orthopedic site you are being seen for		
<b>LUNG</b>		
Do you have a chronic cough		
<b>GASTROINTESTINAL</b>		
In the past few months have you had any nausea or vomiting		
<b>SKELETAL</b>		
Have you ever been told you have:		
Arthritis		
Dislocated Joint		
Chronic Infection		
Torn ligament		
<b>EAR, NOSE AND THROAT</b>		
Do you have a hearing loss		
Do you have acute or ongoing dental problems		
<b>CARDIOVASCULAR</b>		
Have you had phlebitis or blood clots in the veins of your legs		
<b>URINARY</b>		
Have you had a kidney or bladder infection in the last month		
<b>NEUROLOGICAL</b>		
Have you been treated for depression		
Have you ever had seizures		
<b>ENDOCRINE/HEMATOLOGY</b>		
Are you being treated for anemia		
Do you have a blood disease		
Are you thirsty all the time		

**FAMILY HISTORY:** Please indicate if your blood relative had any of the following and their relationship to you

Arthritis, Gout	
Lung Disease	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease/High Blood Pressure	
Kidney Disease	
Other	

**REASON FOR VISIT:** (Circle One)

Is this due to an on the job injury? NO YES Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

Is this a sports Injury? NO YES Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

Is this an auto accident? NO YES Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

Other Accidental Injury? NO YES Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

How did this happen? \_\_\_\_\_

**If you had an injury what body part was injured (list right or left)** \_\_\_\_\_

**State the reason for your visit today: R L Knee \_\_\_\_\_ Shoulder \_\_\_\_\_ Other \_\_\_\_\_**

IS THERE AN ATTORNEY REPRESENTING YOUR INJURY? NO YES

Name of Attorney: \_\_\_\_\_ Name of Firm: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: # \_\_\_\_\_

**Please present your Insurance Card(s) and some form of Identification to the receptionist upon arrival.**

INSURANCE INFORMATION: (Enter all insurance information)

**Subscribers NAME \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_**

1. **Primary Insurance:** \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

2. **Secondary Insurance:** \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Group#: \_\_\_\_\_ ID#: \_\_\_\_\_ Subscribers's DOB \_\_\_\_\_ SS# \_\_\_\_\_

Employer Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Person responsible for bill: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

On this document at the date indicated, a copy of my signature will-serve as the original for all legal purposes, including release of medical records to insurance carriers and/or other physicians.

I also certify that all statements and answers provided by me on this form are complete and true to the best of my knowledge.

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

**Patient, parent or guardian's signature:** \_\_\_\_\_