Straith Orthopedics
COMMITTED TO YOU

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Last name:	First:	Middle:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name / former name?	Birth date: / /	Sex: ❑ M ❑ F	Marital status: Single / Mar / Div / Sep / Wid

Address:			
Apt./ Lot number:	City:	State:	Zip Code:

Home phone number:	Cell phone number:
Email:	Consent to text: ❑ Yes ❑ No
Language (if other than English):	
Online Patient Portal access? ❑ Yes ❑ No	Would you like to share your health information to other providers who use Athena Health Records? ❑ Yes ❑ No

How did you hear about us?

❑Referred by Dr. _____ ❑ Internet Search ❑ Insurance Company

❑Family / Friend ❑ Other_____

PHARMACY INFORMATION

Name:	Phone number:		
Address or street name:	City:	State:	Zip Code:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone number:

INSURANCE

Name of Primary Insurance:	Secondary Insurance:
Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Name of Subscriber:
Subscriber DOB:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Straith Hospital or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date: _____

23901 Lahser Road ▫ Southfield, MI 48033 ▫ T: (248) 386-7278

PLEASE RETURN COMPLETED FORM TO A STAFF MEMBER

Straith Orthopedics

Patient Full Name: _____ Today's Date: _____

Date of Birth: _____ Referring Physician: _____

Primary Care Provider: _____ Do you want notes sent to your PCP? ☐ YES ☐NO

NEW ORTHOPEDIC PROBLEM INFORMATION

What is the primary orthopedic concern you are here for today? _____
(body part)

Which side(s)? ☐Right ☐Left ☐Both

How long have your symptoms/pain been present?

_____Days ____ Months ____ Years

How did your presenting problem occur?

- ☐ No injury- just started hurting
- ☐ Sports (which sport) _____
- ☐ Motor Vehicle Accident
- ☐ Work; work comp claim? ☐YES ☐ NO
- ☐ Other_____

Date of onset/injury *(if applicable)*: ____/_____/_____

Describe your injury *(if applicable)*: _____

_____

List previous surgeries for this problem ☐ NONE
(include date & surgeon if able)

_____

_____

_____

Prior imaging you have had for this problem: ☐ NONE

- ☐ X-ray Date: _____ Location: _____
- ☐ MRI Date: _____ Location: _____
- ☐ CT Date: _____ Location: _____
- ☐ EMG Date: _____ Location: _____
- ☐ Other: _____

Problems: (check ALL that apply)

- ☐ Sharp stabbing pain
- ☐ Swelling
- ☐ Locking
- ☐ Popping
- ☐ Numbness/tingling
- ☐ Sleep disturbance
- ☐ Dull aching pain
- ☐ Instability/ giving way
- ☐Catching
- ☐Clicking/cracking
- ☐ Burning
- ☐Radiating/shooting pain

Other: _____

Pain context:(check one)

☐ Constant ☐ Intermittent (comes and goes)

Rank the severity of your pain (circle # that applies)
(0= none, 10 worst pain)

At rest: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

Previous treatments: (check ALL that apply)

- ☐ NSAIDs (ex. Motrin/ibuprofen)
- ☐ Physical therapy
- ☐ Home exercise program
- ☐ Steroid injection
- ☐ Viscosupplement injections
- ☐ Narcotic Pain Medication: _____
- ☐ Tylenol
- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Bracing

Other: _____

What makes you pain worse?

_____

_____

What makes your pain better?

_____

_____

Patient/Guardian Signature: _____ Date: _____/_____/____

(Office use only) Reviewed by: _____ Initials: _____ Date: _____/_____/____

Straith Orthopedics

NEW PATIENT INTAKE

Patient's Full Name: _____ Today's Date: _____

Date of Birth: ____/____/_____ Age: _____ Height: _____ Weight: _____lbs. Sex: ☐Male ☐Female

Primary Care physician: _____ Office phone #: _____

Office fax #: _____

Preferred pharmacy: _____ Pharmacy phone #: _____

Medications, Vitamins, and Supplements: List ALL medications you are currently taking ☐NONE

MEDICATION NAME	DOSAGE	FREQUENCY

Allergies/Immunologic:

Are you allergic to latex? ☐NO ☐YES

Are you allergic to metals? ☐NO ☐YES

Are you allergic to any medications? ☐NO ☐YES If YES, what medications:_____

Please list any other allergies you may have:

_____

Any poor reactions with prior anesthesia? ☐NO ☐YES

If YES, please described reaction: _____

Do you have a history significant for multiple infections? (MRSA, VRE, C. Diff) ☐Yes ☐No

Family History: *(if YES, circle family member(s) who apply)*

Stroke	☐Yes	☐No	Mother	Father	Sibling
Heart attack/heart disease	☐Yes	☐No	Mother	Father	Sibling
Cancer	☐Yes	☐No	Mother	Father	Sibling
High blood pressure	☐Yes	☐No	Mother	Father	Sibling
Diabetes	☐Yes	☐No	Mother	Father	Sibling

Other family history: _____

Social History:

Advanced directives: ☐NO ☐YES Code status: ☐ Full code ☐ limited code ☐ DNR (do not resuscitate)

Work status: ☐Employed / Occupation _____ ☐Unemployed ☐Retired ☐Disabled

Last date worked *(if applicable)*: _____

Hobbies/ sports: _____

Smoking status: ☐ Never
☐ Former smoker; quit date: _____years smoked: _____
☐ Current smoker; packs per day: _____ years smoking: _____

Use of e-cigarette or vape products? ☐NO ☐YES If Other, what product: _____

Do you drink alcohol? ☐NO ☐YES If YES, how many drinks per week: _____

Any illegal drug use or substance abuse? ☐NO ☐YES If YES, what substance: _____

Marital status: ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPERATED ☐WIDOWED

Religion Preference: _____

Living arrangements: ☐LIVE ALONE ☐LIVE WITH OTHERS Do you feel safe? ☐NO ☐YES

Hand Dominance? ☐RIGHT ☐LEFT ☐BILATERAL

Able to perform activities of daily living? ☐NO ☐WITH DIFFICULTY ☐ABLE TO PERFORM

HEALTH INFORMATION

Past Surgical History: *(Please list any surgeries you have had including dates)* ☐ NO history of surgery

_____

_____

Past Medical History:

Acid Reflux (GERD)	☐Yes	☐No	Hepatitis (B or C)	☐Yes	☐No
Anemia	☐Yes	☐No	High Cholesterol	☐Yes	☐No
Anxiety	☐Yes	☐No	Hypertension	☐Yes	☐No
Arthritis	☐Yes	☐No	Irregular heartbeat	☐Yes	☐No
Asthma	☐Yes	☐No	Kidney Insufficiency	☐Yes	☐No
Autoimmune Disease	☐Yes	☐No	Kidney Stones	☐Yes	☐No
Bladder Problems	☐Yes	☐No	Liver Disease	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	MRSA Exposure	☐Yes	☐No
Blood Clot (DVT/PE)	☐Yes	☐No	Mental Health Disorder	☐Yes	☐No
COPD/Emphysema	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Cancer	☐Yes	☐No	Psoriatic Arthritis	☐Yes	☐No
Chronic Pain	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Depression	☐Yes	☐No	Seizures	☐Yes	☐No
Diabetes	☐Yes	☐No	Sleep Apnea	☐Yes	☐No
Enlarged Prostate (MALES)	☐Yes	☐No	Skin Ulcers	☐Yes	☐No
Fainting Episodes	☐Yes	☐No	Stomach Ulcers	☐Yes	☐No
Fibromyalgia	☐Yes	☐No	Stroke	☐Yes	☐No
Gout	☐Yes	☐No	Substance Abuse	☐Yes	☐No
Headaches	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Heart Attack (MI)	☐Yes	☐No	Tuberculosis (TB)	☐Yes	☐No
Heart Disease	☐Yes	☐No	Ulcerative Colitis	☐Yes	☐No
Heart Stents	☐Yes	☐No			

Other health problems:

_____

Review of Systems: Please check **ALL** that apply to your health

Constitutional /General:
- ☐ Feeling unwell
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Fever

Cardiovascular:
- ☐ Chest pain
- ☐ Swelling in legs
- ☐ Leg ulcers
- ☐ Poor circulation
- ☐ Irregular heartbeat
- ☐ Heart catheterization
- ☐ Stents
- ☐ Open heart surgery
- ☐ Pacemaker/defibrillator
- ☐ History of heart attack

Pulmonary/Respiratory:
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Snoring/ stop breathing
- ☐ Wheezing
- ☐ Sleep apnea

Gastrointestinal:
- ☐ Diarrhea
- ☐ Constipation
- ☐ Jaundice
- ☐ Stomach pain
- ☐ Persistent vomiting

Neurological:
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Paralysis
- ☐ Tremors
- ☐ Restless legs
- ☐ Frequent headaches

Integumentary/Skin:
- ☐ Rash
- ☐ Itching
- ☐ Skin cancer

Musculoskeletal:
- ☐ Joint pain
- ☐ Back problems
- ☐ Joint swelling
- ☐ Muscle aches

Ears, Nose, and Throat:
- ☐ Tooth pain
- ☐ Cavities
- ☐ Recent tooth abscess
- ☐ Bleeding gums
- ☐ Nasal discharge/ runny nose
- ☐ Difficulty swallowing
- ☐ Hearing loss
- ☐ Lumps/ masses

Eyes:
- ☐ Red eyes
- ☐ Vision changes
- ☐ Discharge from eyes

Genitourinary:
- ☐ Urinary frequency
- ☐ Incomplete emptying of the bladder
- ☐ Urgency of urination
- ☐ Burning/pain with urination
- ☐ Incontinence
- ☐ Frequent infections

Psychiatric:
- ☐ Bipolar disease
- ☐ Depression
- ☐ Anxiety
- ☐ Drug/ alcohol abuse

Endocrine:
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Thyroid problems
- ☐ Diabetes

Hematological:
- ☐ Bleeding problems
- ☐ History of blood transfusion
- ☐ History of blood clot
- ☐ Anemia

Patient/Guardian Signature: _____ Date: _____/_____/____

(Office use only) Reviewed by: _____ Initials: _____ Date: _____/_____/____

Straith HOSPITAL
COMMITTED TO YOU
Straith Hospital for Special Surgery
23901 Lahser Road
Southfield, MI 48033-6035

PATIENT'S CONSENTS, AUTHORIZATIONS AND CONDITIONS OF ADMISSION

Patient Name: _____ Date of Birth: _____

Today's Date: _____

This document applies to care and treatment I receive at Straith Hospital for Special Surgery and its outpatient clinics, including in-person and telemedicine services (individually and collectively referred to as "Straith Hospital").

CONSENT TO MEDICAL SERVICES

I authorize and consent to medical, diagnostic, and therapeutic procedures and treatment, and authorize the physicians, mid-level professionals and other healthcare providers who may be involved in my care to provide such treatment, items and services as deemed reasonably necessary or advisable for the care I am seeking or as may otherwise be advisable for my well-being. These include, but are not limited to, diagnostic, radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, medical, nursing and hospital care, and telemedicine services.

I understand, acknowledge and agree that:

1. Practice of medicine is not an exact science, and that no guarantees, promises or assurances have been, or can be, made to me regarding the results that may be obtained, the likelihood of success or the consequences that may follow any in-person or telemedicine service, examination, treatment or diagnosis, or any procedure, test or surgery performed at Straith Hospital.

2. In emergency situations, it may be necessary or advisable for the physicians to perform additional or extended services beyond those contemplated at the time of admission in order to preserve my life and health, and I consent to these services.

3. My treatment and care are directed by my physician, and that the Straith Hospital personnel render care and services according to my physician's instructions. I understand that health care providers in training, including medical students and resident physicians, may be involved in my care and treatment, and I consent to their involvement.

4. The physicians on staff at Straith Hospital are not all employees or agents of Straith Hospital, and some are independent contractors or independent physicians who have been granted the privilege of using the facility for the care and treatment of their patients. I understand that a physician may not always be in the Hospital; however, there is **ALWAYS** a physician on call.

CONSENT TO TESTING

I consent to collecting specimens of my blood, urine, tissue or other bodily fluids in connection with diagnostic testing or other procedures ordered by my physician, and I authorize the examination, use, storage and disposal of all tissue, fluids and specimens removed from my body. I understand that if any health care provider at Straith Hospital sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open

 Patient or Patient Advocate / Representative Initials: ____

wound or other significant exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or RPR; and I consent to such testing. The results of any such testing will be treated confidentially.

CONSENT TO THE USE OF BLOOD PRODUCTS

I consent to the use of blood, blood plasma or blood products, if the physician(s) think it is reasonably necessary. I realize that complications (including the transmission of hepatitis, AIDS or other communicable diseases) may sometimes occur unavoidably and inherently from the receipt of blood, blood plasma or other blood products.

NOTICE OF PRIVACY PRACTICES

I have received and reviewed the Straith Hospital's Notice of Privacy Practices that contains information about how Straith Hospital may use and disclose certain protected health information (or "PHI", as this term is defined by HIPAA), whether in paper, electronic, photographic and other format, that identifies me and that may consist of my past, present or future physical or mental health or condition and/or the provision of health care items or services to me. Straith Hospital may, from time to time, change its privacy practices, consistent with the requirements of HIPAA and the State of Michigan requirements.

USE AND DISCLOSURE OF HEALTH INFORMATION

Straith Hospital and its employed and other physicians authorized to provide medical services at Straith Hospital, mid-level professionals, other health care providers and staff have the right to use and disclose PHI, such as medical records and information about the appointments, tests, treatments, and/or other information pertinent to the health care or payment for the items and services provided to me at Straith Hospital, for all activities that are included within the definitions of "treatment," "payment" and "health care operations" (as these terms are defined by HIPAA) and for other lawful purposes, as described in more detail in the Straith Hospital's Notice of Privacy Practices. I understand, acknowledge and consent to the use and disclosure of my PHI for these purposes.

PROCUREMENT OF INFORMATION

I authorize Straith Hospital to obtain my PHI from other health care professionals and providers (including physicians, hospitals, nursing homes, home health agencies, pharmacies and other health care facilities) as may be necessary for my health care or to facilitate treatment, and authorize all of these health care professionals and providers to disclose my PHI to Straith Hospital. This authorization covers multiple requests for and disclosures of PHI.

PATIENT RIGHTS AND RESPONSIBILITIES

I have received and reviewed the Patient Rights and Responsibilities booklet and have had an opportunity to review its contents.

I understand that I have the right, and the responsibility, to participate in and make decisions concerning my care and treatment, including the right to refuse medical and surgical procedures. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and present complaints, and to follow an agreed upon treatment plan. I agree to participate and cooperate in my own care and treatment. I understand that my health care providers will treat me with respect, and I agree to do the same for them.

Concerns regarding care and safety of the surgical or medical treatments being provided to me should be directed to the Hospital Compliance/Grievance Coordinator at (248) 357-3360 Extension 172. Unresolved concerns may be directed to the Michigan Department of Licensing and Regulatory Affairs (LARA) at (800) 882-6006 or The Joint Commission (TJC) at (800) 994-6610.

PATIENT PERSONAL PROPERTY

I have been informed that Straith Hospital strongly discourages bringing personal valuables, such as personal electronic devices, cell phones, money, jewelry or other articles of value, into the Hospital. I assume full responsibility for all of these items and any of my or my family members' other valuables and articles that are brought into any Straith Hospital location, and agree that Straith Hospital will not be responsible or liable for any loss or damages to any such items. I have the responsibility to store items such as dentures, glasses and hearing aids in an appropriate container that will be provided.

ADVANCE DIRECTIVE

I acknowledge receipt of Notice to Patients and Hospital's Policy Statement on Advance Directives (*Medical Treatment Decisions for Competent and Incompetent Patients*).

_____ I have an Advance Directive (*e.g.*, living will, health care surrogate declaration, durable power of attorney) and request that it govern my care if I am unable to make decisions. I understand that it is my responsibility to provide, and I agree to provide, Straith Hospital with a copy of my Advance Directive and any subsequent changes to my Advance Directive.

_____ Advance Directive attached (copy placed in Patient Chart)
_____ Advance Directive not attached (Patient / Family asked to provide)

Patient Advocate Name: _____ Contact Number: _____

_____ I do not have an Advance Directive

CERTIFICATION

I certify that I have read or had this PATIENT'S CONSENTS, AUTHORIZATIONS AND CONDITIONS OF ADMISSION form (4 pages) read and/or explained to me, that I fully understand the information, consents and authorizations provided above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient to provide the consents and authorizations described herein and to sign this document.

References to "I", "you", "me", and "my" in this document refer to the person listed as the Patient, even though a Patient Advocate or representative signs it on behalf of or for the Patient. If this document is signed by a Patient Advocate or representative, then such person represents and warrants to Straith Hospital that he or she has the necessary power and authority to execute this document and to make decisions regarding the health care of the Patient, and agrees to indemnify, defend and hold Straith Hospital harmless in connection with any breach of this representation and warranty. Straith Hospital may and shall treat, rely and enforce all statements made by Patient's next of kin, legal agent or guardian to the fullest extent permitted by law.

I acknowledge that I can receive a copy of this form upon request.

_____ _____

Patient Signature or, if Patient is unable to sign, Signature of Patient Advocate / Representative

Date

If Patient is unable to sign, secure signature of Patient Advocate, Representative, Next of Kin and indicate reason why Patient is unable to sign: ___ Minor ___ Disoriented ___ Incompetent ___ Medically Unstable

_____

Name of Patient Advocate / Representative and Relationship to Patient (Please print)

☐ *Documents of Relationship to Patient Attached*

_____ _____

Witness

Date

Patient or Patient Advocate / Representative Initials: _____