Instructions for the New Patient Information

1) Please thoroughly complete the following information to the best of your knowledge

2) Upon completion, you will need to PRINT form

3) Once you PRINT form you may either mail, fax or bring paperwork with you on the day of your appointment

PERFORMANCE ORTHOPEDICS
24255 THIRTEEN MILE ROAD, STE. 100
BINGHAM FARMS, MICHIGAN 48025

FAX: 248.988.8565

Joseph Guettler, MD
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24255 Thirteen Mile Road, Suite 100
Bingham Farms, Michigan 48025

Phone: 248.988.8085
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Current Date

Saluation | Last Name | First Name | Middle

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Birthdate | SSN | Email Address

Martial Status | Do you reside in a nursing home? ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Employment Status | Employer

Primary Doctor | City | Home Phone

Referring Doctor | City | Home Phone

Is Patient Over 18 Years Old? ☐ Yes ☐ No

Responsible Party*

COMPLETE THIS SECTION ONLY OF PATIENT IS UNDER 18

*The responsible party is the person bringing the minor to the appointment

Saluation | Last Name | First Name | Middle

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Birthdate | SSN | Email Address

Martial Status | Sex ☐ Male ☐ Female

Employment Status | Employer

Preferred Language | Ethnicity | Race

Notice of Privacy Practices

☐ I have been provided with a copy of the Notice of Privacy Practices and consent to the use of my protected health information for the purpose of treatment, payment and health care operations as described in the notice.

Financial Policy

☐ I have been provided with a copy of the Performance Orthopedics Financial Policy and I hereby assign, transfer and set over to Performance Orthopedics, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits and process any claim. This authorization shall remain valid until written notice is given by me revoking it. I understand that I am responsible for all charges whether or not they are covered by insurance.

Last Name | First Name | Birthdate

Insurance Information

Primary Insurance Company

Contract/Policy ID # | Group Number | Effective Date

Patient Student Status | Name of School

Who holds the insurance?

Fill out this section ONLY if "other" is chosen above for primary insurance holder

Last Name | First Name | Middle | Birthdate

Relationship to patient | SSN | Sex ☐ Male ☐ Female

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Email Address

Employment Status | Employer

Secondary Insurance Company

Contract/Policy ID # | Group Number | Effective Date

Patient Student Status | Name of School

Who holds the insurance?

Fill out this section ONLY if "other" is chosen above for secondary insurance holder

Last Name | First Name | Middle | Birthdate

Relationship to patient | SSN | Sex ☐ Male ☐ Female

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Email Address

Employment Status | Employer

If Medicare is secondary Insurance, choose reason

Last Name _____ First Name _____ Birthdate _____

Injury Information

Is this visit related to a workers compensation injury? ☐ Yes ☐ No Is this visit related to an auto accident injury? ☐ Yes ☐ No

Is this visit for an injury with a pending legal claim? ☐ Yes ☐ No Is this claim related to an injury? ☐ Yes ☐ No

**If yes is answered to ANY of the above questions, continue answering this page. If no is answered to ALL of the above questions, continue to the next page.*

NOTE: If this claim is a result of an injury or accident, the following details are required by the insurance company for payment of your claim. If we have incomplete or inaccurate information, the claim will be denied and the balance will be your responsibility. Please help us to insure accurate information for proper handling of your claim. Thank you!

Date of injury _____ Place of injury/accident (city and state) _____

Circumstances of injury/accident:
How did it happen? (when, where, how, etc.) _____

If Auto Related or Workers Compensation, complete the following information

Name of Insurance Company _____

Address _____ City _____ State _____ Zip _____

Phone _____ Adjuster's Name _____

Claim Number _____ Insured Name _____

Is this claim in dispute? ☐ Yes ☐ No

☐ The above information is true to my knowledge

Last Name _____ First Name _____ Birthdate _____

Patient Medical Information Form

Past Medical History: Please indicate any medical illnesses or conditions that you currently are being treated for or those that you have had within the last 10 years. Explain the kind of problem you have or had, and the type of treatment that you received. If NONE, write "NONE"

Past Surgical History: Please list any surgical procedures that you have had. Please include the year, type of procedure, doctor and hospital. Also, list any problems or complication that you had during or after any of the surgeries listed (for example: blood clots, anesthesia problems, infections, etc.) If NONE, write "NONE"

Family History: Please list any significant medical problems for any blood relations (parents, grandparents, brothers or sisters) also list any medical problems that tend to run in the family. If NONE, write "NONE"

Social History:

Smoking _____ Alcohol _____

What kind of work do you do? _____ Do you exercise on a regular basis? _____

Review of Systems: Do you have any of the following symptoms? Check all that apply. If nothing is checked, it will be listed that you do not have any of the listed symptoms.

Allergic/Immunologic:	☐ Frequent infections	☐ Sensitive to many foods/medicines		
Cardiovascular:	☐ Chest pain	☐ Palpitations	☐ Poor circulation	☐ Swelling in extremities
Endocrine:	☐ Always thirsty	☐ Always hot	☐ Always cold	
Gastrointestinal:	☐ Heartburn	☐ Nausea	☐ Vomiting	☐ Diarrhea ☐ Bloody Stools
Genitourinary:	☐ Painful urination	☐ Difficulty urinating	☐ Bladder problems	☐ Frequent urinary infections
Hematologic/ Lymphatic:	☐ Easy bruising	☐ Excessive bleeding	☐ Painful lymph nodes	
	☐ Frequent leg swelling	☐ Phlebitis		
Integumentary:	☐ Rashes	☐ Skin irritations	☐ Skin ulcers	
Musculoskeletal:	☐ Achy swollen joints	☐ Stiff joints	☐ Soft tissue trigger points	
Neurological:	☐ Poor memory	☐ Headaches	☐ Poor balance	☐ Loss of consciousness
	☐ Fainting	☐ Muscle wasting	☐ Uncontrollable movements	
Ophthalmologic:	☐ Blurred vision	☐ Light sensitivity		
Otolaryngologic:	☐ Sinus problems	☐ Trouble swallowing	☐ Ringing in ears	
Psychiatric:	☐ Anxiety	☐ Depression	☐ Bizarre thoughts	☐ Paranoid thoughts
Respiratory:	☐ Shortness of breath	☐ Difficulty breathing	☐ Wheezing	☐ Coughing

☐ None of the above symptoms

Last Name | First Name | Birthdate

Height | Weight

Medications

Preferred Pharmacy | Location (street & city) | Phone Number

Please list all medications that you are currently taking including vitamins and supplements

Medication name & strength	Reason for medication	Medication name & strength	Reason for medication

☐ Not currently taking medication

Allergies

Please list all allergic reactions you have to medications and the type of reaction caused

☐ No known Drug Allergies

Additional space for medical, surgical, family history or medications

By typing my full name in the space below, I hereby certify that I have read this form and attest the information I have provided is accurate and up to date.

Print Form