Dearborn Heights Office:
5111 Auto Club Dr, Dearborn, MI 48126
Tel. (313) 749-0370 | Fax. (313) 447-2234

INSIGHT SURGICAL HOSPITAL

Center for Minimally Invasive Surgery

Warren Office:
21230 Dequinder Rd. | Warren, MI 48091
Tel. (586) 354-2530 | Fax. (586) 620-6036

Date:

Patient's Name:	Sex:	Age	Date of Birth
	❑ Male ❑ Female		

Height:	**Weight:**
Dominant Hand: ❑ Left	❑ Right
Rate Your Pain : 1-10 (10 being the worst)	

ALLERGIES: ❑ NONE

ANESTHETICS	DRUG	FOOD	METAL	OTHER
❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

SOCIAL HISTORY:

❑ YES ❑ NO	**Do you smoke cigarettes?** If yes, _____ packs per Day/Week
❑ YES ❑ NO	**Recreational Drugs?** If yes, what type & amount? _____
❑ YES ❑ NO	**Alcohol?** If yes, _____drinks per Day/Week
❑ YES ❑ NO	**Caffeine?** If yes, _____drinks per Day/Week
❑ YES ❑ NO	**CURRENTLY ABLE TO WORK?**
❑ YES ❑ NO	If **No** is it due to this problem? Last time you worked _____
❑ YES ❑ NO	**ARE YOU PREGNANT?**

Do you travel? ❑ Local ❑ State ❑ Nation ❑ International

Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

REFERRING DOCTOR *(Name and Phone Number)*

FAMILY DOCTOR *(Name and Phone Number)*

HOW DID YOU HEAR ABOUT US?

MEDICATION(S): ❑ NONE *(Please list your current medications)* Circle any medications you feel you have become addicted to.

Name	Dosage	Name	Dosage	Name	Dosage	Name	Dosage

SURGICAL/HOSPITALIZATION HISTORY: ❑ NONE *(Please list your surgeries/hospitalizations with approximate dates)*

FAMILY HISTORY: *(Serious illness for example bleeding, blood clot, heart attack)*

FATHER	ALIVE / DECEASED	
MOTHER	ALIVE / DECEASED	
PATERNAL GRANDFATHER	ALIVE / DECEASED	
PATERNAL GRANDMOTHER	ALIVE / DECEASED	
MATERNAL GRANDFATHER	ALIVE / DECEASED	
MATERNAL GRANDMOTHER	ALIVE / DECEASED	

NOTICE OF PRIVACY PRACTICES

Our office's Notice of Privacy Practice explains your rights and our policies regarding the protection of your personal health information. It is always kept here posted at the front desk. We are required by federal law to show it to you and get your signature to acknowledge that we have done so. If you would like, you may read it before you sign this or we can give you a copy to take home. Please sign below.

ACKNOWLEDGMENT OF RECEIPT OF OFFICE PRIVACY POLICY AND FINANCIAL POLICY

I acknowledge that Insight Orthopedic Specialists, Insight Neurosurgery, and/or Insight Comprehensive Therapy (hereby referred to as "Insight") "Notice of Privacy Practices" and "Financial Policy" has been provided to me. I understand that I have the right to review Insight's Notice of Privacy Practices and the Financial Policy prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations with Insight. It describes my rights as they concern the limited use of health information-including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for Insight is also provided on request at the main administration desk of the facility. Insight reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy the revised Notice of Privacy Practices by calling the facility and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment. I also read and agree to the policies of the Financial Policy by signing below.

_____ _____

Signature of Patient or Personal Representative — Date

_____ _____

Name of Patient or Personal Representative — Description of Personal Representative's Authority

PLEASE FLIP OVER

Authorization to Treat:
I authorize my provider to proceed with any care plan that is discussed and that I have consented to. I also authorize my provider to proceed with any procedure that I agree to in the office including but not limited to injections, aspirations, and mass excisions. I understand that I have discussed the risks and benefits with my physician to my satisfaction.

Signature of Patient/Legal Guardian:_____ Date: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I AUTHORIZE INSIGHT ORTHOPEDIC SPECIALISTS THE REQUEST TO RELEASE ANY OF MY MEDICAL RECORDS FROM ANY HOSPITAL OR OTHER FACILITY I HAVE BEEN TREATED. I ALSO AUTHORIZE THE FOLLOWING PEOPLE TO BE SPOKEN TO IN REGARDS TO MY MEDICAL CARE:

NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP

SIGNATURE **DATE**

MEDICAL HISTORY

Check ALL conditions that apply to you ❑NONE

High Blood Pressure
___Essential Primary Hypertension (I10)

Blood Clots/Embolism
___Personal History of other venous thrombosis and embolism (Z86.718)

Diabetes
____ Type 2 diabetes with diabetic neuropathy (E11.40)
____ Type 2 diabetes with unspecified complications (E11.8)
____ Type 2 diabetes unspecified (E11.9)

COPD
____ Chronic obstructive pulmonary disease (J44.9)

High Cholesterol
___Pure Hypercholesterolemia, Unspecified (e78.00)

Chronic Bronchitis
____ Simple chronic bronchitis (J41.0)

Asthma
_____Unspecified asthma (J45.909)

Arthritis
___Unsepcified Osteoarthritis (M19.90)

Osteoporosis
____ Age-related osteoporosis without current pathological fracture (M81.0)

Pacemaker
___ Presence of cardiac pacemaker (Z95.0)

Heart Attack
___Old Myocardial Infarction (I25.2)

TIA (Mini Stroke)
___Transient Cerebral Ischemic Attack, Unspecified

Ulcers
___Personal History of Diseases of the skin and subcutaneous tissue (Z87.2)

Emphysema
____ Other emphysema (J43.8)

Rheumatoid Arthritis
____ Rheumatoid arthritis with rheumatoid factor (M05.9)
____ Rheumatoid myopathy with rheumatoid arthritis of unspecified site (M05.40)

Hepatitis C
____ Chronic viral hepatitis C (B18.2)

Cirrhosis of the liver
____ Alcoholic cirrhosis of liver without ascites(K70.30)
____ with ascites (K70.31)
____ Other chirrhosis of liver (K74.69)

Renal/Kidney disease
____ End stage renal disease (N18.6)
____ Chronic kidney disease stage 1 (N18.1)
____ Chronic kidney disease stage 2 (N18.2)
____ Chronic kidney disease stage 3 (N18.3)
____ Chronic kidney disease stage 4 (N18.4)
____ Chronic kidney disease stage 5 (N18.5)

Alzheimers/Dementia
____ Alzheimer's disease with early onset (G30.0)
____ Alzheimer's disease with late onset (G30.1)
____ Alzheimer's unspecified (G30.9)
____ Unspecified dementia without behavioral disturbance (F03.90)
____ Unspecified dementia with behavior disturbance (F03.91)

Depression/Bipolar Disorder
____ Major depressive disorder, recurrent, moderate (F33.1)
____ Bipolar II disorder (F31.81)
____ Other bipolar disorder (F31.89)

Schizophrenia
____ Paranoid schizophrenia unspecified (F20.0)
____ Unspecified schizophrenia (F20.3)

Multiple Sclerosis
____ Multiple sclerosis (G35)

Epilepsy/Seizures
____Other epilepsy not intractable (G40.802)
____ Seizures (G40.89)

Heart Failure/Atrial Fibrillation/Unstable Angina
____ Heart failure unspecified (I50.9)
____ Unspecified atrial fibrillation and atrial flutter (I48.9)
____ Unstable angina (I20.0)

Stroke
____ Other cerebral infarction (I63.8)
____ Cerebral infarction unspecified (I63.9)

Cancer: _____
What type? _____
Others: _____

ARE YOU ON BLOOD THINNERS: ❑ No ❑ Yes: Name _____ Why? _____

DO YOU HAVE ANY METAL IN YOUR BODY: ❑ No ❑ Yes: Where? _____

HISTORY OF PRESENT ILLNESS

OCCUPATION (DESCRIBE YOUR JOB DUTIES) | **ACTIVE RETIRED DISABLED DATE**

CHIEF COMPLAINT:

Dear Patient: You will be asked questions regarding race and ethnicity during the registration process. We do not ask these questions to limit or deny you services. We ask these questions to give you better care. By gathering this data, we can better prevent, test for, and treat the diseases or health conditions that may affect you. You may refuse to provide us with this information. You will only be asked these questions once.

RACE ❑ Asian ❑Black, African or African American ❑American Indian or Alaskan Native ❑White ❑ Native Hawaiian or other Pacific Islander ❑Other Races ❑Two or more races ❑Unknown

ETHNICITY ❑ Hispanic or Latino ❑ Neither

WAS THIS AN INJURY? | **INJURY DATE OR BEGAN AS AN ISSUE** | **TYPE OF CLAIM** ☐ **INSURANCE CLAIM** ☐ **WORKER'S COMP** ☐ **AUTO CLAIM** ☐ **OTHER** _____

HOW DID THIS INJURY OCCUR?

WHAT MAKES THE PROBLEM WORSE? | **WHAT MAKES THE PROBLEM BETTER?**

WERE ANY OF THE FOLLOWING TAKEN OF THE AREA? WHEN & WHERE?

❑X-RAY_____ **❑MRI**_____ **❑CT SCAN**_____ **❑EMG**_____ **❑MYELOGRAM**_____

SYMPTOMS: **❑NUMBNESS/TINGLING** **❑WEAKNESS** **❑NECK PAIN** **❑NIGHT PAIN**

❑SWELLING **❑INSTABILITY** **❑SHOOTING PAIN** **❑RADIATING PAIN**

❑DIFFICULTY WITH OVERHEAD ACTIVITIES **❑DIFFICULTY WALKING UP AND DOWN STAIRS**

HAVE YOU TRIED: **❑PHYSICAL THERAPY** **❑INJECTIONS** **❑SPLINTING** **❑MEDICATION(S)**

DID YOU UTILIZE: **❑CRUTCHES** **❑WHEELCHAIR** **❑BRACE** **❑CAST** **❑SPLINT**

ARE YOU ON DISABILITY? ☐YES ☐NO

ARE YOU IN THE PROCESS OF OBTAINING DISABILITY? ☐YES ☐NO

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	**POLICY HOLDER'S RELATIONSHIP TO PATIENT**	**POLICY HOLDER'S BIRTHDATE**
CONTRACT / ID NUMBER		**GROUP**

SECONDARY

INSURANCE COMPANY/CARRIER		
POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER		GROUP

PATIENT INFORMATION

YOUR STREET ADDRESS	CITY AND STATE	ZIP CODE	SOCIAL SECURITY NO.
E-MAIL	HOME PHONE NO. ( )		CELL PHONE NO. ( )
PATIENT'S EMPLOYER (NAME & ADDRESS)			WORK PHONE NO. (INCLUDE EXT.) ( )
PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP		PHONE NO. ( )

PHARMACY NAME | PHONE NO. | FAX NO

PLEASE FLIP OVER →

Review of Symptoms (check if applicable)

General
- ❑ Weakness
- ❑ Tiredness
- ❑ Excess Appetite
- ❑ Weight Loss
- ❑ Chills
- ❑ Fever
- ❑ Difficulty Sleeping

Cardiovascular
- ❑ Chest Pain or Tightness
- ❑ Need to sit up to breathe
- ❑ Heart Racing
- ❑ Irregular Heartbeat
- ❑ Heart Murmur
- ❑ Swelling of the legs
- ❑ Varicose Veins
- ❑ Leg Pain at rest
- ❑ Leg Pain with exertion

Respiratory/Pulmonary
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Bloody Sputum
- ❑ Pain with Breathing
- ❑ Gag, choke or cough during sleep
- ❑ Snore
- ❑ Stop breathing during sleep
- ❑ Excessive daytime sleepiness
- ❑ Wake up unrefreshed

Musculoskeletal
- ❑ Muscle pain
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Arm Pain
- ❑ Pain down your legs
- ❑ Painful or stiff joints
- ❑ Redness of any joints

Neurologic - Psychiatric
- ❑ Seizures
- ❑ Headaches
- ❑ Blackouts
- ❑ Dizziness
- ❑ Double Vision
- ❑ Weakness of Limbs
- ❑ Loss of Balance
- ❑ Loss of Sensation
- ❑ Loss of Coordination
- ❑ Speech Problems
- ❑ Depression
- ❑ Problems with Memory
- ❑ Problems with Thinking

Male Reproductive
- ❑ Lump in testicles
- ❑ Discharge from penis
- ❑ Decreased Sex-Drive
- ❑ Erection Problems

Female Reproductive
- ❑ Decreased Sex-Drive
- ❑ Unusual Vaginal Bleeding
- ❑ Pregnancy
- ❑ Hormone Therapy

HEENT
- ❑ Decreased Ability to See
- ❑ Blurred Vision
- ❑ Pain in Eyes
- ❑ Difficulty Hearing
- ❑ Ringing in Ears
- ❑ Discharge from Ears
- ❑ Frequent nasal discharge

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Abdominal Pain
- ❑ Bright Red Blood in stools
- ❑ Black stools
- ❑ Change in bowel habits

Urinary
- ❑ Difficulty with Urination
- ❑ Pain with urination
- ❑ Urinary Tract Infection
- ❑ Loss of Bladder Control
- ❑ Frequent Urination

Endocrine
- ❑ Goiter
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Increased Thirst
- ❑ Change in Voice
- ❑ Change in foot/hand size
- ❑ Change in breast size

Skin
- ❑ Change in mole
- ❑ Breast lumps
- ❑ Itching
- ❑ Rash
- ❑ Redness or Infection

Hematologic
- ❑ Easy Bruising
- ❑ Prolonged Bleeding