



**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_

FIRST MI LAST

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ E-MAIL : \_\_\_\_\_

WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_

EMERGENCY NUMBER: (A FRIEND, NEIGHBOR, OR RELATIVE OTHER THAN A HOME NUMBER): (\_\_\_\_\_) \_\_\_\_\_

BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ MALE FEMALE

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ lbs MARITAL STATUS: \_\_M \_\_S \_\_D \_\_W

PATIENTS SOCIAL SECURITY NUMBER: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

WHO WERE YOU REFERRED BY? \_\_\_\_\_

WHAT IS THE REASON FOR THE APPOINTMENT? \_\_\_\_\_

WHAT KIND OF INSURANCE DO YOU HAVE? \_\_\_\_\_

IS YOUR PROBLEM RELATED TO AN INJURY? \_\_Y OR \_\_N

WAS THIS AN AUTO ACCIDENT? \_\_Y OR \_\_N DATE OF INJURY: \_\_/\_\_/\_\_

WAS THIS AN ON THE JOB INJURY? \_\_Y OR \_\_N

DO YOU HAVE RECENT X-RAYS FOR YOUR PROBLEM? \_\_Y OR \_\_N

PARTY RESPONSIBLE FOR BILL: \_\_\_\_\_

\*\*INSURANCE INFORMATION (SUBSCRIBER IS THE PERSON WHOSE EMPLOYER IS PROVIDING THE INSURANCE)

SUBSCRIBERS NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_

WORK PHONE NUMBER: \_\_\_\_\_

- 1.) I HEREBY AUTHORIZE DR. KASSAB, TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN. THIS INFORMATION MAY BE SENT BY U.S. MAIL OR FAX MACHINE.
- 2.) I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. KASSAB FOR ALL SERVICES RENDERED.
- 3.) I UNDERSTAND THAT IF DR. KASSAB IS NOT A PARTICIPATING PROVIDER FOR MY INSURANCE, THAT I AM RESPONSIBLE FOR THE REMAINING AMOUNT UNPAID BY MY INSURANCE.

**X** \_\_\_\_\_ DATE: \_\_\_\_\_

\*\* IF YOUR COMMERCIAL OR THIRD PARTY INSURANCE DOES NOT PAY THE BILLING AMOUNT IN FULL, THE BALANCE WILL BE YOUR RESPONSIBILITY.



**CONFIDENTIAL QUESTIONNAIRE**

ARE YOU UNDER A PHYSICIAN'S CARE?  Y OR  N FOR WHAT CONDITION? \_\_\_\_\_

PHYSICIAN'S NAME AND ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

LIST ANY SURGERIES: \_\_\_\_\_  
\_\_\_\_\_

REASONS FOR ANY HOSPITALIZATIONS IN THE PAST 5 YEARS: \_\_\_\_\_  
\_\_\_\_\_

DO YOU SMOKE?  Y OR  N  CIGARS  CIGARETTES  PIPE PACKS PER DAY: \_\_\_\_\_ NO. OF YEARS: \_\_\_\_\_

DO YOU DRINK ALCOHOL?  Y OR  N  RARE  OCCASIONAL  DAILY

**DO YOU HAVE ANY OF THE FOLLOWING:**  **NONE**

<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	EPILEPSY
<input type="checkbox"/>	JAUNDICE	<input type="checkbox"/>	HEART ATTACK
<input type="checkbox"/>	INFLAMMATORY RHEUMATISM	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	ASTHMA / HAY FEVER
<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	HIVES OR SKIN RASH
<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	KIDNEY PROBLEM
<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	ARTHRITIS
<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	HYPOGLYCEMIA
<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	

**IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING:**  **NONE**

<input type="checkbox"/> Spine Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hip Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other	

**LIST ANY / ALL MEDICATION(S) OR DRUG(S) YOU MAY BE TAKING:**

MEDICATION	DOSE / FREQUENCY	MEDICATION	DOSE / FREQUENCY
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

**ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING:**  **NONE**

<input type="checkbox"/> Local Anesthesia	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Codeine	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Cortisone
<input type="checkbox"/> Other			

DO YOU HAVE ANY OTHER DISEASE, CONDITION, OR PROBLEM THAT YOU THINK DR. KASSAB SHOULD KNOW ABOUT? PLEASE EXPLAIN: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN OF PATIENT

\_\_\_\_\_  
DATE



Safa S. Kassab, M.D., P.C

**WE look forward to serving all your orthopedic needs in one of our offices:**

## **PONTIAC OFFICE**

44555 WOODWARD AVE.

STE 105

PONTIAC, MI. 48341

PHONE: 248 -335 - 2977

## **CLARKSTON OFFICE**

6770 DIXIE HWY

STE 311

CLARKSTON, MI. 48346

PHONE: 248 - 858 - 3855

**Please be sure you bring the following:**

- > Photo ID and insurance card(s)**
- > Please download and fill out the 2 previous forms**
- > ANY X-RAYS TAKEN OF THE PROBLEM AREA**
- > Any medical reports or test results pertaining to your problem**
- > Current list of medications with strength and dosage**
- > If your visit is for a hip or knee problem please bring shorts or loose fitting clothing to help facilitate your visit**

**Our PONTIAC office is located approximately one mile North of Square Lk Rd in the St. JOE'S MEDICAL OFFICE BUILDING connected to the North side of the hospital. This building is on the West side of Woodward, and our office is in suite 105 on the first floor.**

**Our CLARKSTON office is located approximately 1 block North of M-15 on the east side of Dixie Hwy. Take I-75 North to exit 93, turn south on Dixie. Our office will be on the left, just before M-15, or Ortonville Rd. Or take I-75 to exit 91 (Clarkston / Davison exit). Turn south on M-15 "Ortonville Rd". At the fifth stop light turn right, you will see signs directing you to our parking lot.**

**\*\*IF YOU HAVE AN HMO INSURANCE: you must make sure a referral gets to our office before your appointment. Without a referral, we will have to reschedule. We suggest you give our office a call 1 to 2 days prior to your appointment to verify that your referral is here, authorizing the proper procedures. Also, you MUST BRING X-RAYS**

**We look forward to taking care of your orthopedic needs. If you should have any additional questions please do not hesitate to give us a call.**

**IF THIS IS A WORK RELATED INJURY YOU MUST HAVE AUTHORIZATION FAXED TO OUR OFFICE PRIOR TO APPOINTMENT!!!!**

**Thank You.**