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248-335-2977

Safa S. Kassab, MD
Maher J. Bahu, MD
Joseph P. Ward, M.D.
William S. Ward, MD

PATIENT INFORMATION

PATIENT NAME _____
FIRST MI LAST

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

HOME PHONE: _____ **E-MAIL:** _____

WORK PHONE: _____ **MOBILE:** _____

RACE _____ **ETHNICITY** _____ **PREFERRED LANGUAGE** _____

EMERGENCY CONTACT NAME AND NUMBER _____

BIRTH DATE: ____ **MALE** _____ **FEMALE** _____

HEIGHT _____ **WEIGHT** _____ **lbs** **MARITAL STATUS:** ____ **Married** ____ **Single** ____ **Divorced** ____ **Widowed**

PATIENT SOCIAL SECURITY NUMBER _____

WHO WERE YOU REFERRED BY? _____

WHAT IS THE REASON FOR THE APPOINTMENT? _____

WHICH DOCTOR ARE YOU SEEING? ____ **DR. BAHU** ____ **DR. KASSAB** ____ **DR. J. WARD** ____ **DR. W. WARD** ____ **PA/NP**

WHAT KIND OF INSURANCE DO YOU HAVE? _____

IS YOUR PROBLEM RELATED TO AN INJURY? _____ **YES** _____ **NO**

WAS THIS AN AUTO ACCIDENT? _____ **YES** _____ **NO** **DATE OF INJURY:** _____

WAS THIS INJURY WORK RELATED? _____ **YES** _____ **NO** **DATE OF INJURY:** _____

PARTY RESPONSIBLE FOR BILL: _____

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

SUBSCRIBERS NAME: _____ **SUBSCRIBERS DOB:** _____

SUBSCRIBERS ADDRESS IF DIFFERENT THAN PATIENT: _____

EMPLOYER: _____ **WORK PHONE NUMBER:** _____

EMPLOYERS ADDRESS: _____

1.) I HEREBY AUTHORIZE OSOC, 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 OSOC FOR ALL SERVICES RENDERED.
3.) I UNDERSTAND THAT IF OUR PRACTICE 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.

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NAME:_____

ARE YOU UNDER A PHYSICIAN'S CARE? _____ **YES** _____ **NO** **FOR WHAT CONDITION?** _____

PHYSICIANS NAME AND ADDRESS: _____

LIST ANY SURGERIES: _____

REASONS FOR ANY HOSPITALIZATIONS IN THE PAST 5 YEARS: _____

DO YOU SMOKE? _____ **YES** _____ **NO** **FORMER SMOKER?** _____ ***IF YES, PLEASE SELECT:***

____ ***CIGARS*** _____ ***CIGARETTES*** ____ ***PIPE***

PACKS PER DAY: _____ **NO. OF YEARS:** _____

DO YOU DRINK ALCOHOL? _____ **YES** _____ **NO** ***IF YES, PLEASE CIRCLE:*** ____ ***RARE*** ____ ***OCCASIONAL*** ____ ***DAILY***

DO YOU HAVE ANY OF THE FOLLOWING:

	RHEUMATIC FEVER		**EPILEPSY**
	JAUNDICE		**HEART ATTACK**
	INFLAMMATORY RHEUMATISM		**STROKE**
	HEPATITIS		**STOMACH ULCER**
	DIABETES		**ASTHMA / HAY FEVER**
	HIGH BLOOD PRESSURE		**HIVES OR SKIN RASH**
	ANEMIA		**KIDNEY PROBLEM**
	ARTHRITIS		**NONE**

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

	Cancer	Diabetes	Heart Problems	LIST HEART OR OTHER PROBLEMS:
MOTHER ALIVE DECEASED **FATHER ALIVE DECEASED**				

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	**Penicillin**	**Sulfa**	**Antibiotics (Please Specify)**
Codeine	**Aspirin**	**Iodine**	**Cortisone**
Local Anesthesia	**Others:**		

DO YOU HAVE ANY OTHER DISEASE, CONDITION, OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT? PLEASE EXPLAIN:

PRINT NAME **SIGNATURE OF PATIENT OR GUARDIAN OF PATIENT** **DATE**

Committed to Excellence in Orthopedics
OSOC
Orthopedic Specialists of Oakland County

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Rx Policy

For your convenience, our office will e-prescribe any prescriptions directly to your pharmacy, when possible. Please help us to update your file:

Patient Name: _____

DOB: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Address: _____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name: _____

Primary Care Physician's Phone Number: _____

Primary Care Physician's Fax Number: _____

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

BLOOMFIELD OFFICE
44038 WOODWARD AVE.
STE 200
BLOOMFIELD, MI. 48302

PHONE: 248 -335 - 2977

CLARKSTON OFFICE
6060 DIXIE HWY
STE F
CLARKSTON, MI. 48346

PHONE: 248 -335 - 2977

The BLOOMFIELD office is located approximately one mile North of Square Lake Rd. This building is on the east side of Woodward, and our office is in suite 200 on the second floor.

Our CLARKSTON office is located approximately 3/4 mile south 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, after Maybee road. Or take I-75 to exit 91 (Clarkston / Davison exit). Turn south on M-15 “Ortonville Rd” to Dixie. Turn left on Dixie to 6060 Dixie Hwy on the east side of the road.

Important Information for your upcoming appointment:

Please be sure you bring the following:

- **Photo ID and insurance card(s)**
- **The attached forms, filled out**
- **Any X-Rays and/or MRI studies of the problem area**
- **Any medical reports or test results pertaining to your problem**
- **A current list of medications with strength and dosage**

*****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 has been sent and that it gives authorization for the office visit and the proper procedures.

***** IF YOUR INJURY IS WORK OR AUTO RELATED:*** you must have authorization from the insurance company sent to our office prior to appointment. Without an open claim letter, we will have to reschedule your appointment.

We look forward to taking care of your orthopedic needs. If you should have any additional questions, please do not hesitate to call our office.