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248-335-2977

Safa S. Kassab, MD
Maher J. Bahu, MD

PATIENT INFORMATION

PATIENT NAME ______________________________
FIRST MI LAST

ADDRESS: ______________ CITY: ______________ STATE: ______________ ZIP ______

HOME PHONE: ______________ E-MAIL : ______________

WORK PHONE: ______________ MOBILE: ______________

RACE ______ ETHNICITY ______ PREFERRED LANGUAGE ______

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 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 DRS KASSAB OR BAHU 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? ☐Y OR ☐N FOR WHAT CONDITION?

PHYSICIANS NAME AND ADDRESS:

LIST ANY SURGERIES:

REASONS FOR ANY HOSPITALIZATIONS IN THE PAST 5 YEARS:

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

DO YOU DRINK ALCOHOL? ☐N OR ☐Y ☐*RARE* ☐*OCCASIONAL* ☐*DAILY*

DO YOU HAVE ANY OF THE FOLLOWING: ☐ NONE

☐	RHEUMATIC FEVER	☐	EPILEPSY
☐	JAUNDICE	☐	HEART ATTACK
☐	INFLAMMATORY RHEUMATISM	☐	STROKE
☐	HEPATITIS	☐	STOMACH ULCER
☐	DIABETES	☐	ASTHMA / HAY FEVER
☐	HIGH BLOOD PRESSURE	☐	HIVES OR SKIN RASH
☐	LOW BLOOD PRESSURE	☐	KIDNEY PROBLEM
☐	ANEMIA	☐	ARTHRITIS
☐	TUBERCULOSIS	☐	HYPOGLYCEMIA
☐	HEART MURMUR	☐	

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

☐ Spine Problems	☐ Arthritis	☐ Hip Disease	☐ Diabetes	Heart Problems
☐ Tuberculosis	☐ Hypertension	☐ Cancer	☐ 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.	
		14.	

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING:

☐ NONE	☐ Penicillin	☐ Sulfa	☐ Antibiotics
☐ 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

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Rx Policy

Our office has changed to electronic prescriptions. To better accommodate you, our office would like to obtain some additional information. Please help us update your file.

Patient Name:

DOB:

PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Number: Fax:

Address:

Primary Care Physician's Name:

Primary Care Physician's Number:

Primary Care Physician's Fax:

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

PONTIAC OFFICE	CLARKSTON OFFICE
44555 WOODWARD AVE. STE 105 PONTIAC, MI. 48341 PHONE: 248 -335 - 2977	6060 DIXIE HWY STE F CLARKSTON, MI. 48346 PHONE: 248 - 858 - 3855

Please be sure you bring the following:

- **photo ID and insurance card(s)**
- **the attached forms, filled out**
- **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**

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 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.**

****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. Also, you should bring any X-rays or other studies that have been performed.**

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 SENT TO OUR OFFICE PRIOR TO APPOINTMENT!!!!

Thank You.