

Welcome To Our Office!

Welcome to The Porretta Center for Orthopaedic Surgery. Please find enclosed the new patient registration forms for you to fill out prior to your scheduled appointment. We want your first visit and every visit thereafter to be as pleasant an experience as possible. We feel that by letting you know in advance what you will need at the time of your visit that your visit will go much more efficiently.

When you arrive for your appointment, please arrive 15 minutes early to register with our receptionist. Please also make sure to bring the following with you to your appointment:

1. All health insurance card (s);
2. Your driver's license (if patient is a minor, then the driver's license of the guarantor);
3. Any X-ray, MRI or other films and their reports (if you have had any taken);
4. If a Workers' Compensation carrier is to be billed, please bring written authorization that includes, the insurance company name, address, phone number, claim number, date of injury, and adjusters name;
5. If an Auto insurance carrier is to be billed, please bring the insurance company's name, address, phone number, claim number, date of injury, and adjusters name.
6. If you are covered by an HMO, you must bring a referral form from your primary care physician. The Managed Care Services have instructed us not to see patients without a referral. If you do not bring your referral with you, you may be asked to reschedule your appointment;
7. A current list of medications with should include any over the counter medications, herbal and vitamin supplements and the dosage;
8. A pharmacy name and telephone number;

Office co-pays and services not covered by your insurance are due at the time of your visit. You will be billed for deductibles. For your convenience we accept Cash, Checks, Visa, Master Card, Discover and American Express.

If you have any questions regarding any of the above or need to cancel or reschedule you appointment, please feel free to contact our office at 248-349-7015. We look forward to seeing you soon.

Sincerely,

John P. O'Hara, M.D.

Jefferey E. Michaelson, M.D.

David C. Markel, M.D.

Sean F. Bak, M.D.

William Higginbotham, M.D.

Todd Frush, M.D.

James C. Bolz, M.D.



22250 Providence Drive, Suite 401
Southfield, Michigan 48075
OFFICE (248) 349-7015 • FAX (248) 569-0364

26750 Providence Parkway, Suite 200
Novi, Michigan 48374
OFFICE (248) 349-7015 • FAX (248) 449-1763



PATIENT REGISTRATION FORM

Patient Name _____ SS # _____ DOB ____ - ____ - ____

Address _____ City _____ State _____ Zip _____

1st Phone _____ 2nd Phone _____ M or F

Employer _____ Occupation _____

Marital Status S ___ M ___ D ___ W ___ Spouse's Name _____ DOB ____ - ____ - ____

FOR A MINOR: FINANCIALLY RESPONSIBLE PERSON

Name _____ SS# _____ DOB ____ - ____ - ____ M or F

Address (If different from patient) _____ City/State/Zip _____

1st Phone _____ 2nd Phone _____ Relationship to Patient _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION

Please provide your insurance card(s) to be copied. If your insurance information is not received within 24 hours, you will be billed for the services rendered.

Please mark all that apply:

The patient DOES NOT HAVE INSURANCE _____ If yes, DATE OF THE INJURY _____

This visit is related to an AUTO ACCIDENT _____ If yes, DATE OF THE INJURY _____

This visit is related to an INJURY AT WORK _____ If yes, DATE OF THE INJURY _____

Adjustor's Name/Phone# _____

Billing Address _____

Claim # _____

HEALTH INSURANCE:

1st Insurance Co Name _____ Effective Date ____ - ____ - ____

Policy Holder Name _____ DOB ____ - ____ - ____

2nd Insurance Co Name _____ Effective Date ____ - ____ - ____

Policy Holder Name _____ DOB ____ - ____ - ____

I authorize the release of medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered to me. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for any charges incurred that are not covered by my insurance company including, but not limited to, co-pays and deductibles that may apply with my insurance policy and that these payments are due at the time of service. I have read this information and understand it.

I have received a copy and the HIPPA patient privacy act. I understand that my information cannot be released to unauthorized persons without my written consent.

Signature: _____ Date: _____

PATIENT MEDICAL INFORMATION

Name: _____ DOB _____ - _____ - _____

Referring Physician/City/Phone/Fax _____

Primary Care Physician/City/Phone/Fax _____

What problem brings you to see the Doctor? _____

If an injury, how/where did it happen? _____ Date of Injury _____

HEIGHT: _____ WEIGHT: _____ HANDED: L or R Are you pregnant? Y or N

Pharmacy Name: _____ Phone: _____

CURRENT MEDICATIONS:

Name of Medication:	Dosage:	How often?	Why?

Please list all surgeries, including Orthopaedic:

Past Surgeries:	Year:

Please list any complications following surgery:

Signature: _____ Date: _____