



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

Patient Information

PATIENT NAME: _____

FIRST MI LAST

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: (_____) _____ E-MAIL : _____

WORK PHONE: (_____) _____ MOBILE: (_____) _____

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: _____

SUBSCRIBERS DATE OF BIRTH: _____

SUBSCRIBERS ADDRESS IF DIFFERENT THAN PATIENT: _____

EMPLOYERS ADDRESS: _____

WORK PHONE NUMBER: _____

- 1.) I HEREBY AUTHORIZE ORTHOPEDIC SPECIALISTS OF OAKLAND COUNTY 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, FAX MACHINE OR ELECTRONICALLY.
- 2.) I AUTHORIZE PAYMENT DIRECTLY TO ORTHOPEDIC SPECIALISTS OF OAKLAND COUNTY FOR SERVICES RENDERED.
- 3.) I UNDERSTAND THAT IF DR. KASSAB OR BAHU 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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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:

<input type="checkbox"/> NONE	<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"/> Local Anesthesia	<input type="checkbox"/> Others:		

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

PRINT NAME

SIGNATURE OF PATIENT
OR GUARDIAN OF PATIENT

DATE



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www.osocortho.com

Dear Patient,

Recently 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.

Thank you,

OSOC

Patient Name: _____

DOB: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Pharmacy Address: _____

Primary Care Physicians Name: _____

Primary Care Physicians Phone Number: _____

Primary Care Physicians Fax Number: _____



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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

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 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.