Welcome to the Beaumont Orthopedic Institute

We are pleased that you have chosen us to serve your Orthopedic needs. The focus of our facility is to provide residents with an exceptional education experience while ensuring the highest quality health care services to our patients. Therefore, your wait time may vary depending on the amount of time that the attending physician will need to spend teaching the resident.

Enclosed you will find a map for your convenience and the necessary forms for registration. We ask that you arrive fifteen minutes prior to your scheduled appointment time to complete your registration.

Along with your forms bring the following:

- **Photo ID**
- **Insurance Card(s)**
- **Referral** (For H.M.O. Insurance)

If a referral is not obtained by your scheduled appointment time, but is required, <u>your appointment will be rescheduled to another date and time.</u>

- **Guardianship Documents** (If applicable)
- **Test Results**

All Records pertaining to the problem that our physician will be seeing you for Especially a CD of your X-rays, MRI and/or CT scan along with the reports for all procedures that were not performed at a Beaumont facility is <u>REQUIRED</u> for your visit. Please, also bring list of medications with doses and all of your Doctors names and phone numbers. <u>You will be rescheduled to another date and time if you do not have these at the time of your appointment.</u>

If this visit is due to an **Auto Accident** or **Workman's Compensation** claim.....
Bring the following:

<u>Auto Claims</u>

*Open claim Letter *Claim Number-*Date of Accident-
*Billing Address-*Phone Number-*Case Manager

<u>Workman's Comp</u>

*Letter of Authorization-*Claim Number-*Date of Injury-
*Billing Address-*Case Manager

If you are unable to meet any of the above requirements please call **(248) 551-9100 option #1** as soon as possible to reschedule.

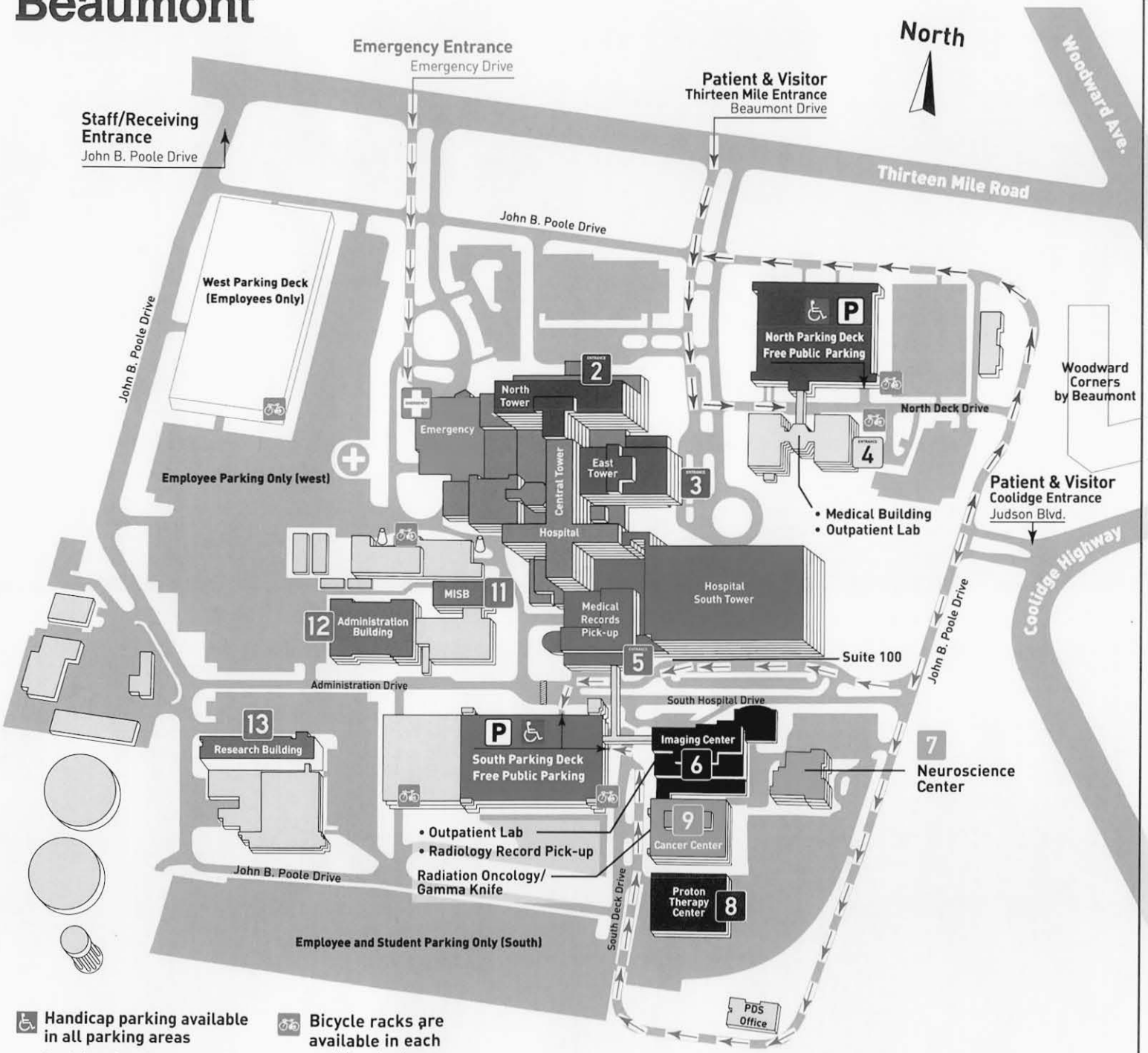
We look forward to serving you!

Your appointment is with Dr. _____

Appointment Date: _____ **Appointment Time:** _____

3535 W Thirteen Mile, Ste 742, Royal Oak, MI 48073 Phone (248) 551-9100 Fax (248) 551-9131

Beaumont



Handicap parking available in all parking areas
Special equipped oversize vehicles - see door attendant

Bicycle racks are available in each parking deck.

H Beaumont, Royal Oak
3601 West Thirteen Mile Rd
Royal Oak, MI 48073
248-898-5000

Emergency Center Entrance

2 North Entrance

3 East Entrance

4 Medical Building Outpatient Lab
3535 West Thirteen Mile Rd
Royal Oak, MI 48073

5 South Entrance and Medical Records Pickup

6 Imaging Center Outpatient Lab Radiology Record Pick-up
3581 West Thirteen Mile Rd
Royal Oak, MI 48073

7 Neuroscience Center
3555 West Thirteen Mile Rd
Royal Oak, MI 48073

8 Proton Therapy Center
3571 West Thirteen Mile Rd
Royal Oak, MI 48073

9 Cancer Center Radiation Oncology Gamma Knife
3577 West Thirteen Mile Rd
Royal Oak, MI 48073

11 MISB

12 Administration Building
3711 West Thirteen Mile Rd
Royal Oak, MI 48073

13 Research Building
3811 West Thirteen Mile Rd
Royal Oak, MI 48073

P Free Public Parking 24 hours/day:
North Parking Deck
NORTH Blue
South Parking Deck
SOUTH Green

1050 111819 OSM

Beaumont Hospital, Royal Oak
Patient and Visitor Parking Information
(Information subject to change)

Hospital Parking

Free parking is available in the North (blue) Parking Deck and South (green) Parking Deck.

Valet Parking

Valet parking can be accessed at the North, South, East and the Cancer Center entrances for a fee.

The valet parking hours of service are:

North Entrance -

Monday through Friday – 5:30 a.m. to midnight
Weekends and holidays – 8 a.m. to midnight

East Entrance -

Monday through Friday – 5:30 a.m. to 9 p.m.
Cars can be retrieved from 9 – 11 p.m. at the South Entrance valet.
Weekends and holidays – Closed

South Entrance -

Monday through Friday – 5 a.m. to 11 p.m.
Weekends and holidays – 8 a.m. to 11 p.m.

Cancer Center -

Monday through Friday – 6 a.m. to 4:30 p.m.
Weekends and holidays – Closed

Emergency Entrance –

24 hours a day, seven days a week

All cars left in valet parking after closing can be retrieved by calling Security – 248-898-0911 or ext. 80911 using a Beaumont phone.

Day of discharge parking

Please speak to the patient's nurse on the day of discharge or refer to the discharge brochure in the patient's room to determine which entrance to use. Drive to that entrance and speak with the attendant, who will direct you either to the valet or free parking area.

1050 111819 OSM

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HEALTH HISTORY
(Confidential)

Patient Name: _____ Today's Date: _____

Birthdate: _____ Referred By: _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Anxiety
- ☐ Balance problems
- ☐ Chills
- ☐ Clumsiness
- ☐ Depression
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Excessive hair loss
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Hot flashes
- ☐ Increased stress
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats
- ☐ Tremors

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips ☐ Groin
- ☐ Back ☐ Legs ☐ Face
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Lack of bladder control
- ☐ Difficulty/pain urinating

GASTROINTESTINAL
- ☐ Bowel changes
- ☐ Lack of bowel control
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Rapid heart beat
- ☐ Swelling of ankles

EYE, EAR, NOSE, THROAT
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Sinus problems

SKIN
- ☐ Bruise easily
- ☐ Itching
- ☐ Rash
- ☐ Sore that won't heal

MEN only
- ☐ Other male specific problems

_____

_____

WOMEN only
- ☐ Other female specific problems

_____

_____

Date of last menstrual period _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had.

- ☐ ADD/ADHD
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bi-polar
- ☐ Bleeding Disorders
- ☐ **Blood Clots**
- ☐ Bronchitis
- ☐ Cancer_____
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Cirrhosis
- ☐ COPD
- ☐ Diabetes
- ☐ Downs Syndrome
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures_____
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis Type A, B, C
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Legally Blind
- ☐ Liver Disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other_____

_____

Family History (check all that apply and indicate their relationship to you):

- ☐ Heart disease _____
- ☐ Stroke _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Major neck or back problems _____
- ☐ Seizures _____
- ☐ Lung disease _____
- ☐ Hypertension _____
- ☐ Osteoporosis _____
- ☐ Scoliosis _____

Social History:

Do you exercise? ☐ Yes ☐ No Type of exercise: _____ Times per week: _____

Do you smoke? ☐ Yes ☐ No Numbers of cigarettes per day _____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week

Job/Occupation _____

How long have you been in current position? _____

Are you able to work now? _____

Is your current problem related to work or an accident? _____

Is there an attorney working with you? _____

Are you or have you been a victim of domestic violence? _____

Would you like to talk to someone? ☐ Yes ☐ No Would you like someone to contact you? ☐ Yes ☐ No

CONTINUED ON BACK

List all medications (PRESCRIPTIONS and N-PRESCRIPTION) you are presently taking. Include frequency and dose.

MEDICATION NAME	DOSE	HOW OFTEN PER DAY
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• **Are you taking any blood thinners** (Coumadin, Heparin, Plavix, Aspirin)		
•		
•		

List **all** allergies

List all surgical procedures you have had and the approximate date.

SURGICAL PROCEDURE	DATE

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Legal Guardian Signature: _____

Reviewed by: _____ Date: _____