Matthew H. Kopera MD
Board Certified Orthopedic Surgery

Patient Registration/Demographics

Last Name: _____ **First Name**:_____ **Middle Initial**:_____

Preferred Name if different from above:_____

Date of Birth:_____ **Sex:** _____

Address:_____ **City**:_____
State: _____ **Zip code**:_____

Home Phone:_____ **Mobile Phone**:_____

Work Phone:_____ **E-Mail**:_____

Last four digits of SSN#:_____ **Beaumont MRN # (if known):**_____

Contact Preference (Please Circle One): Home Phone / Mobile Phone / Text / Work Phone

Marital Status (Please Circle One): Married / Single / Domestic Partner/ Divorced/ Widowed

Race (Please circle one): Caucasian / African American / Asian / Native American / More than one / Refused

Ethnicity (Please circle one): English / Italian / Polish / Spanish / Arabic / French / Greek / Hindi / Refused

Language (Please circle one): English / Italian / Polish / Spanish / Arabic / French / Greek / Hindi / Refused

Primary Care Physician:_____

Pharmacy Name and Phone #:_____

How did you hear about us?_____

Emergency Contact Information:

Name: _____ **Phone**:_____ **Relation to patient:**_____

HIPAA / Privacy Acknowledgement/Medical Release of Information

Matthew H. Kopera MD requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You have the right to refuse to sign this acknowledgement if you wish. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

I authorize Matthew Kopera MD to release/discuss my medical records/laboratory/radiology results and reports to the following individuals:

Please note your primary care physician will be sent a summary after your first visit

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

1701 E. South Blvd Suite #140
Rochester Hills MI 48307

53950 Van Dyke, Suite A
Shelby Township, MI 48316

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General Consent for Treatment

1. **Consent:** I request and authorize medical and surgical treatment as may be deemed necessary and appropriate byMatthew H. Kopera MD and his designee and assistants participating in my care. The care may include diagnostic, radiology, laboratory procedures, anesthesia, therapeutic procedures, drugs, and hospital care. I understand if a surgical procedure is performed I will sign a separate informed consent.
2. **Payment and Financial Responsibility:** I assign and authorize payment from my insurance company directly to Matthew H. Kopera MD for any and all services rendered. I agree to pay in a timely manner any charges not covered by my insurance company. I understand that it is my primary responsibility to pay Matthew H. Kopera MD all charges for services rendered irrespective of any disputes or disagreements between myself and the insurance companies. I also understand that co-pays and balances are due at the time of service. If a referral is required to be seen in this office by my insurance company, it is my sole responsibility to obtain the correct documentation from my primary care physician.
3. **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of care and treatment which I have hereby authorized.
4. **Valuables:** I release the practice of Matthew H. Kopera MD from responsibility for all personal articles which I have with me during the time I am a patient in the office. I understand that the practice is not responsible for clothing, eye glasses, jewelry, money, or other personal articles of value kept in my possession while a patient at this practice.
5. **Medication Authorization:** I authorize Matthew H. Kopera MD to access my medication record from my insurance company over the last 13 months to provide the most current and up to date records.
6. **Consent to call and text:** I consent to receive calls and text messages from Matthew H. Kopera MD at the phone number(s) I have listed on my registration form, including my wireless number provided. I understand I may be charged for such calls/texts by my wireless carrier and that such calls may be generated by an automated dialing system.
7. **Office Policies and Procedures:** I acknowledge the receipt of the office policies and procedures. I have read, understand, and agree to the Office Policies and Procedures.

I have read this form, or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time. I understand that to withdraw my consent I must provide the practice with a signed written letter informing them of such withdrawal.

Signature:_____ **Date**:_____

Relation to patient if other than self:_____

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Patient Name:_____ **DOB:**_____

Reason for seeing physician today:_____ right left bilateral

Date of Injury or Onset of Pain:_____ **Height:**_____ **Weight:**_____

Is this a work related injury: Yes No **Is this an auto related injury:** Yes No

If you are being seen for a work or auto related injury please make sure you give **ALL claim information to the receptionist**

MEDICATIONS (Please list ALL medications you are currently taking, you may attach a list if needed)

Medication name	Dose (ie milligrams)	Reason taking medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Are you allergic to any medication? Yes No If yes please list:_____

PAST MEDICAL HISTORY **Please circle all that apply**

Angina	Asthma	Congestive heart disease	Cancer (specify)_____
COPD	Gout	Coronary artery disease	Clotting Disorder (specify)_____
Pseudogout	High Cholesterol	High blood pressure	Thyroid Disorder (specify)_____
Lupus/SLE	Kidney disease/failure	Insulin-dependent diabetes	Non-Insulin dependent diabetes
Osteoarthritis	Peripheral neuropathy	Peripheral vascular disease	Seizure disorder/Epilepsy
GERD/Ulcers	Rheumatoid arthritis	Other not listed (specify)_____	

PAST SURGICAL HISTORY (Please list all prior surgeries performed & year they were performed)

Surgery (Please be as specific as possible) Year

1._____
2._____
3._____
4._____

SOCIAL HISTORY (Please circle and/or write answers)

Hand Dominance: Right Left Ambidextrous

Are you currently employed: Yes No Retired

Occupation: _____

Smoking Status: Never Former Current How much:_____ How many years?_____

Alcohol Intake: None Occasional Moderate Heavy

Illicit Drugs: Yes No If yes what kind: _____

Exercise level: None Occasional Moderate Heavy

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Patient Name: _____ **DOB:** _____

FAMILY MEDICAL HISTORY **(Circle all that apply)**

Diabetes	**mom**	**dad**	**sister**	**brother**
Cancer	**mom**	**dad**	**sister**	**brother**
Stroke	**mom**	**dad**	**sister**	**brother**
High Blood Pressure	**mom**	**dad**	**sister**	**brother**
Blood Clotting Disorder	**mom**	**dad**	**sister**	**brother**
Problems with Anesthesia	**mom**	**dad**	**sister**	**brother**
Rheumatoid Arthritis	**mom**	**dad**	**sister**	**brother**
Osteoarthritis	**mom**	**dad**	**sister**	**brother**

REVIEW OF SYSTEMS (Please circle **ALL symptoms that you have or have had in the last month)**

Constitutional
Fever
Night Sweats
Weight gain ___lbs. (Last 6 mo.)
Weight loss ___lbs. (Last 6 mo.)
Exercise intolerance

Gastrointestinal
Abdominal pain
Vomiting
Change in appetite
Black or tarry stools
Frequent diarrhea
Vomiting blood

Neurologic
Loss of consciousness
Weakness
Numbness
Seizures
Dizziness
Migraines/Frequent headaches
Restless leg

EYES
Dry Eyes
Irritation
Vision changes

Respiratory
Cough
Wheezing
Shortness of breath
Coughing up blood
Sleep apnea

Musculoskeletal
Muscle aches
Muscle weakness
Joint pain
Back pain
Swelling in extremities

Endocrine
Fatigue
Increased thirst
Hair loss
Increased hair growth
Cold intolerance

ENT
Difficulty hearing
Ear pain
Frequent nose bleeds
Nose/Sinus Problems
Sore throat
Bleeding gums
Snoring
Dry mouth
Oral abnormalities
Mouth ulcers

Integumentary (skin)
Abnormal mole
Jaundice
Rash
Itching
Dry skin
Growth/lesions

Lymphatic
Swollen glands
Easy Bruising
Excessive Bleeding

Cardiovascular
Chest pain on exertion
light headed
Known heart murmur
Palpitations

Genitourinary
Urinary loss of control
Difficulty urinating
Increased urinary frequency
blood in urine
Incomplete emptying

Psychiatric
Depression
Sleep disturbance
Restless sleep
Feeling unsafe in relationship
Alcohol abuse

Immunologic
Sinus pressure
Frequent sneezing
Itching/hives
Runny nose

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