

**Robert M. Doane, M.D., P.C.**  
 Orthopedic Surgeon\Sports Medicine & Joint Replacement  
 956 Cooper Street; Jackson, MI 49202  
 Phone (517)787-3900 Fax (517)787-4318

**NAME**-----**Date**-----

**DATE OF INJURY** \_\_\_\_\_

**PLEASE LIST ALL MEDS THAT YOU TAKE DAILY:**

Medicine name: \_\_\_\_\_ Dose: \_\_\_\_\_  
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 -----  
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**Please list all surgeries you have had:**

\_\_\_\_\_  
 \_\_\_\_\_

**Are you allergic to any medication (if yes please list)**

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**Do you have any history of:**

High blood pressure	self	parent	Thyroid disease	self	parent
Heart Disease	self	parent	Stroke	self	parent
Kidney disease	self	parent	COPD	self	parent
AIDs/HIV	self	parent	Hepatitis	self	parent
Rheumatoid Arthritis	self	parent	Difficulty with anesthesia	yes	no

Other \_\_\_\_\_

**Do you have any of the following symptoms: (circle all that apply)**

Depression	Decreased vision	Wheezing
Bipolar disease	Cataracts	Weight loss/gain
Fever	Shortness of breath	Chest pain
Persistent cough	Irregular heart beat	Joint pain
Poor circulation	Muscle aches	Painful urination
Asthma	Diabetes	Paralysis
Bleeding problems	Headaches	Allergies to food
Loss of hearing	Stomach pain	Sinus problems
Diarrhea	Pulmonary Embolism	Skin rashes

**CAVITIES (this is very important when considering joint replacement)**

Do you smoke            yes            no            how many packs per day \_\_\_\_\_  
 Do you drink alcohol    yes            no            how much \_\_\_\_\_  
 Do you use illicit drugs yes            no            how often \_\_\_\_\_  
 Are you pregnant        yes            no

Do you work            full time            part time            Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_

Marital Status (please circle) Married    Single    Widow    Divorced

Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

Patient Height \_\_\_\_\_ Patient Weight \_\_\_\_\_

Have you had Bone Density Testing: Yes \_\_\_ No \_\_\_ If so, when \_\_\_\_\_

**Patient signature** \_\_\_\_\_

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**INDIVIDUAL PATIENT'S AUTHORIZATION**

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Patient's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Your Address: \_\_\_\_\_ Your E-Mail \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Your Telephone Number: \_\_\_\_\_ Your Cell Phone: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

**THE USE AND/OR DISCLOSURE AUTHORIZED**

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use/or disclose the protected health information: 1) Your Primary Physician 2) Your Insurance Company 3) \_\_\_\_\_ 4) \_\_\_\_\_

**CHANGING YOUR MIND ABOUT THIS AUTHORIZATION**

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer of your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

**SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT**

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research related treatment. Also I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

**INDIVIDUAL PATIENT'S SIGNATURE**

I have read the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

You have a right to a copy of this form after you sign it. Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

**BY SIGNING BELOW, YOU ARE ACKNOWLEDGING THE ABOVE AND RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.**

RECEIVED/ACKNOWLEDGED ON THIS DATE: \_\_\_\_\_

RECEIVED/ACKNOWLEDGED BY (SIGNATURE): \_\_\_\_\_

**AUTHORIZATION FOR SERVICE:** I hereby authorize information to be furnished to insurance carriers and/or attorneys concerning my illness and treatment and I hereby assign the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for payment for all services regardless of insurance coverage. If I do not have insurance coverage, I understand that payment is due at the time of service. I understand that if the doctor is not participating with my insurance that I am responsible for any and all charges. I also understand that if I have a deductible that has not been met or a co-insurance due that I am responsible for any and all balances due. The parent who accompanies the dependent child/children is responsible for all fees. I also certify that all information provided is true and accurate to the best of my knowledge.

**EMERGENCY CONTACT**

Name of Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_