GENERAL PATIENT INFORMATION & CONSENT TO TREAT

Patient Last Name:		First Name:					M.I.:			
Date of Birth:	Age:	Sex:	M	F	Marital Status:	S	M	D	Sep	W
Home Address:		City:					Zip:			
Last Four Digits of SSN:	Email Address:	Home Phone #:					Mobile #:			
Employer Name:		Work Phone #:					Ok to leave messages at:	Home	Cell	Work
Is this visit related to an Automobile or Workman's Compensation claim?		Yes		No			If yes, Date of Injury:			
Person to contact in case of emergency:		**Phone #:**					**Relationship:**			

If you are not the insurance policyholder, please complete the information below:

Insured Last Name:	First Name:	M.I.:		
Relationship to Patient:	Date of Birth:	Gender:	M	F

If you have a secondary insurance plan and are not the policyholder, please complete the information below:

Insured Last Name:	First Name:	M.I.:		
Relationship to Patient:	Date of Birth:	Gender:	M	F

Consent for Treatment

By signing below, I (or my authorized representative on my behalf) authorize Dearborn/Livonia Orthopedics & Sports Medicine and their staff to conduct diagnostic examinations, tests, and procedures, and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose, and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test, procedure, available treatment options, and the common risks, anticipated burdens, and benefits associated with these options, as well as alternative courses of treatment.

Right to Refuse Treatment

In giving my general consent for treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and no guarantees have been made to me as to the results of my evaluation and/or treatment.

Patient/Parent/Guardian Signature:	Date: