SMG OB/GYN Lake Lansing – St. Johns

New Patient Questionnaire

(Please Print Clearly and Fill Out Entirely)

Name: _____ Former/ Maiden Name: _____

Date of Birth: _____ Age: _____ Today's Date: _____

Current Gender Identity:

☐Male
☐Female
☐Transgender Male
☐Transgender Female
☐Gender Queer
☐Additional Category (Please Specify):
_____
☐Decline to Answer

Gender Assigned at Birth:

☐Male
☐Female
☐Other
☐Decline to Answer

What pronouns do you prefer we use when talking about/to you (check all that apply):

☐She/Her/Hers
☐He/Him/His
☐They/Them/Theirs
☐Other (Please Specify): _____

Do you identify as (check all that apply):

☐Straight
☐Gay
☐Lesbian
☐Bisexual
☐Other (Please Specify): _____

*Language: _____ Race: _____ Ethnicity: _____

*Do you have any barriers to communication? (please circle) Yes No Please List: _____

Reason for today's visit: _____

Primary Care provider: _____

Who referred you for this visit? _____

How did you hear about our practice? _____

Preferred pharmacy? _____

*Many questions are required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Thank You.

Advanced Directives

*Do you have a Durable Medical Power of Attorney? (Please circle) Yes No

If no, would you like an information packet today? (Please circle) Yes No

Allergies: Please list all allergies including medication, latex, foods, iodine, peanuts, eggs, shellfish etc.

Allergy	**Reaction**

Name: _____ Date of Birth: _____ Today's Date: _____

Medications: Please List ALL current medications including vitamins, herbs, and supplement's

Name of medication	**Dose**	**Amount taken**	**How often**
Ex: Vitamin D	*1,000 IU*	*1 tablet*	*Once daily*

Medical History: Do you have or have you had any of the following: Please check all that apply

( ) Anesthesia Problems	( ) Lung Problems
( ) Breast Problems	( ) Stomach Problems (Ulcer, GERD, etc.)
( ) Heavy/ Irregular Uterine Bleeding	( ) Eating Disorder
( ) Uterine Fibroids	( ) Gallbladder Disease
( ) Abnormal Pap Test / HPV	( ) Colon Problems (Diverticulitis, Colitis, Crohn's etc.)
( ) Pelvic Infection/Sexually Transmitted Disease	( ) Hepatitis / Liver Disease
( ) Vulvar Problems	( ) Kidney Disease
( ) Migraine Headaches	( ) Urinary Incontinence
( ) Epilepsy / Seizures	( ) Lupus
( ) Depression / Mental Illness	( ) Arthritis
( ) Thyroid Disease	( ) Previous Bone Fractures
( ) Diabetes	( ) Osteopenia / Osteoporosis
( ) High Blood Pressure	( ) Back Problems
( ) Stroke	( ) Blood Transfusions
( ) High Cholesterol	( ) Cancer: Type and Year?
( ) Heart Disease / Murmur	( ) Other Serious Illness (Please Describe)
( ) Blood Clot in Leg or Lungs	

Surgical History / Hospitalizations: Please list any surgeries or hospitalizations

Surgery/Hospitalization	**Year**	**Surgery/Hospitalization**	**Year**

Name: _____ Date of Birth: _____ Today's Date: _____

Family History: If you check any of the following, please list relationship of the relative(s)

Ex: Mother = M, Father = F, Sister = S, Brother = B, Maternal Grandmother – MGM, Maternal Grandfather = MGF, Paternal Grandmother = PGM, Paternal Grandfather = PGF, Maternal Aunt = MA, Paternal Aunt = PA, etc.

Problem	**Relationship**	**Problem**	**Relationship**
( ) *Breast Cancer		( ) High Cholesterol	
( ) *Ovarian Cancer		( ) Osteoporosis	
( ) *Uterine Cancer		( ) Emotional Issues	
( ) *Colon Cancer		( ) Mental Health Problems	
( ) Diabetes		( ) Alcoholism	
( ) High Blood Pressure		( ) Birth Defects	
( ) Heart Disease		( ) Other	

Personal and Social History: Please tell us about yourself. This information is intended to help us understand and meet the varied needs of the patients we care for.

How is your general health? ( ) Good ( ) Fair ( ) Poor		
Do you have regular dental check ups? ( ) Yes ( ) No	**Do you have your vision check regularly?** ( ) Yes ( ) No	
Do you have any hearing problems? ( ) Yes ( ) No	**Are you immunizations up to date?** ( ) Yes ( ) No	
Do you eat a healthy diet? ( ) Yes ( ) No	Do you have any weight concerns? ( ) Yes ( ) No	
Do you exercise regularly? ( ) Yes ( ) No	**Do you use seat belts?** ( ) Yes ( ) No	
*Do you do a monthly self breast exam? ( ) Yes ( ) No	Do you take calcium/ vitamin D? ( ) Yes ( ) No	
Have you ever smoked cigarettes? ( ) Yes ( ) No	Amount per day?	
Do you still smoke? ( ) Yes ( ) No	If no, what year did you quit?	If yes, how long have you smoked?
Do you use smokeless tobacco? ( ) Yes ( ) No	Are you interested in quiting? ( ) Yes ( ) No	
Do you drink alcohol? ( ) Yes ( ) No ( ) In recovery	If yes, amount per week?	
Type (ex. Wine, beer, liquor, etc.):	Are you interested in quitting? ( ) Yes ( ) No	
Do you use recreational drugs? ( ) Yes ( ) No ( ) In recovery	How Often?	Last use?
Type (Marijuana, cocaine, meth, etc.):	Are you interested in quitting? ( ) Yes ( ) No	
Have you ever been sexually active? ( ) Yes ( ) No	Birth control? ( ) Yes ( ) No Type:	

Name: _____ Date of Birth: _____ Today's Date: _____

Are you currently sexually active? ( ) Yes ( ) No	If yes, during the past year my partner(s) are (check all that apply): ( ) Monogomous relationship with 1 man ( ) Monogomous relationship with 1 woman ( ) Multiple male partners ( ) Multiple female partners ( ) Both male and female partners Other: _____

*Have you ever been verbally, emotionally, physically, or sexually abused?	( ) Yes ( ) No
Are you currently being verbally, emotionally, physically, or sexually abused?	( ) Yes ( ) No
Do you feel safe in your home?	( ) Yes ( ) No
Do you feel safe in your relationship(s)?	( ) Yes ( ) No

*__Marital Status:__ ( ) Single / Unmarried ( ) Married ( ) Civil Union ( ) Domestic Partnership, Living Together ( ) Partnered, Not Living Together ( ) Separated ( ) Divorced ( ) Widowed ( ) Other:

Living arrangements (ex. Alone, with spouse, children, etc.):

Are you employed? ( ) Yes ( ) No	If yes, where?	Type of work:
*Highest level of education completed?	*What is your best learning method? ( ) Verbal ( ) Written ( ) Visual	

Menstrual History:

Age of first period?	**Last menstrual period began?**
My periods are: Please check all that apply ( ) Regular ( ) Irregular ( ) Normal ( ) Heavy ( ) Painful ( ) Manageable / Tolerable ( ) Unmanageable, I want to talk about options for treatment	
Other Problems (Please List):	

Post- menopausal patients: Please check all that apply **( ) Not applicable**

( ) I have gone through menopause with no bleeding in the last year
( ) I have experienced some vaginal bleeding or spotting in the last year
( ) I am on hormone replacement therapy. List Type:
( ) I have taken hormones in the past and quit in (year):
( ) I am having trouble with hot flashes or night sweats and want to talk about treatment
( ) I have recently been experiencing a diminished sex drive

Contraception: Please check any that apply

( ) IUD	( ) Tubal Ligation	( ) Partner had vasectomy	( ) Birth control Pill
( ) Patch, ring or implant	( ) Condoms	( ) None	( ) Other
( ) Natural Family Planning			

Name: _____ Date of Birth: _____ Today's Date: _____

Gynecological History:

Have you ever had an abnormal pap test? ( ) Yes ( ) No	If yes, what year?
If yes, have you ever had a colposcopy? ( ) Yes ( ) No	If yes, what year?
Other treatment or procedures (ex. LEEP)?	What year?
Ever tested positive for a sexually transmitted disease(ex. Herpes, chlamydia, gonorrhea)?	( ) Yes ( ) No
If yes, list STD and Year:	

Pregnancy History:

Number of pregnancies		Number of live births		Number of premature births	
Number of abortions		Number of miscarriages		Number of living children	

Pregnancy History:

Birth #	Month / Year of Birth	Weight	Gender	Weeks Pregnant	Type of Delivery	Complications

******Last Menstrual Period Began?**_____

Name: _____ Date of Birth: _____ Today's Date: _____

Review of Systems: Have you been experiencing any of the following problems? **( ) No Problems**

General		
( ) Chills	( ) Fatigue	( ) Fever
( ) Hot flashes	( ) Night Sweats	( ) Sleep disturbance
( ) Recent weight loss_____pounds	( ) Recent weight gain_____ pounds	
Head, Eyes, Ears, Nose, and Throat		
( ) Ear pain	( ) Hearing Loss	( ) Ringing in ears
( ) Congestion	( ) Nasal discharge	( ) Nosebleeds
( ) Sore throat	( ) Dental problems	( ) Vision problems
Respiratory		
( ) Shortness of breath	( ) Wheezing	( ) Cough
Cardiovascular		
( ) Chest pain	( ) Swelling	( ) Irregular heartbeat
( ) Heart palpitations	( ) Rapid heart rate	
Gastrointestinal		
( ) Abdominal pain	( ) Bloody stools	( ) Constipation
( ) Diarrhea	( ) Nausea	( ) Vomiting
Gynecology		
( ) Pelvic pain	( ) Painful intercourse	( ) Vaginal discharge
( ) Painful periods	( ) Abnormal vaginal bleeding	( ) Nipple discharge
( ) Vulvar Itching	( ) Breast lump	( ) Genital ulcers
( ) Breast Pain	( ) Urinary frequency	( ) Painful urination
( ) Leaking Urine	( ) Nocturia (night urination)	( ) Urinary urgency
Musculoskeletal		
( ) Joint pain	( ) Joint stiffness	( ) Joint swelling
( ) Muscle pain	( ) Muscle weakness	( ) Limb pain / swelling
Dermatological		
( ) Acne	( ) Skin rash	( ) Mole changes
( ) Skin lesion		
Neurological		
( ) Dizziness	( ) Headaches	( ) Numbness or tingling
( ) Weakness		
Psychological		
( ) Anxiety	( ) Depression	( ) Decreased libido

Patient Registration Information

NOTE: Please complete this form in its entirety. This is a benefit to you to assure accurate billing on your behalf

(PLEASE PRINT LEGIBLY)

(PLEASE PRINT LEGIBLY) Last Name	**First Name**	**MI**	**DOB**

Mailing Address Apt/Lot Number City State Zip	Home Phone Number ( )
Email Address / Social Security Number	Cell Phone Number ( )
Patient Employer / Occupation	Work Phone Number ( )
Employer Address	**Work Status**: __ Self Employed __ Student __Full Time __ Part Time __Not Employed __ Retired (Retirement Date: _____)
Primary Care Physician:	

MEDICARE PATIENTS ONLY- Please Answer the Following Questions:

Are you eligible for black lung benefits? __ Yes __ No	Are you entitled to benefits through the dept. of veteran's affairs? __ Yes __ No
Are you on Medicare for an illness/injury that is due to a work-related accident/condition? __ Yes __ No	Are you eligible for Medicare based on disability? __ Yes __ No
Are you eligible for Medicare based on end- stage renal disease? __ Yes __ No	Are you or your spouse currently employed? __ Yes __ No

PRIMARY HEALTH INSURANCE & POLICY HOLDER INFORMATION – Insurance that will be billed first:

Name of Primary Insurance Company	Policy Number	Group Number

Policy Holder's Name	Relationship to Patient	Birthdate	Social Security Number

Policy Holder's Address (If different from Patient)	Home Phone Number ( )
Policy Holder's Employer Name and Address	Work Phone Number ( )

SECONDARY HEALTH INSURANCE & POLICY HOLDER INFORMATION – Insurance that will be billed second:

Name of Secondary Insurance Company	Policy Number	Group Number

Policy Holder's Name	Relationship to Patient	Birthdate	Social Security Number

Policy Holder's Address (If different from Patient)	Home Phone Number ( )
Policy Holder's Employer Name and Address	Work Phone Number ( )

EMERGENCY CONTACT INFORMATION- Please list a different phone number than the Patient

Name	Relationship	Home Phone Number ( )
Address		Work or Cell Phone Number ( )

GENERAL INFORMATION

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino __ Unknown __ Decline	Race: __ Asian __ Black or African American __ Hispanic __Native American __ Native Hawaiian or other Pacific Islander __ White __Other __ Unknown __Decline
Preferred Language: _____ Do you need an interpreter? __ Yes __ No	How do you prefer to be contacted for preventive reminders? __ MySparrow __ Mail __Phone __ Do not contact
Marital Status: ____ Single/Unmarried ___ Married ___ Civil Union ___ Divorced ___ Domestic Partnership, Living Together ___ Widowed ___ Legally Separated ___ Partnered, Not living Together ___ Other_____	Religion Preference:
Patient/ Guardian **Signature:**	Today's Date:

SMG OB/GYN
Lake Lansing & St. Johns

Missed Appointment Policy

In order to provide quality care to our Patients, improve access, and minimize wait time, our office has adopted the following policy regarding missed appointments.

I understand that if I should miss/cancel without 24 hours' notice a scheduled new patient appointment -or- miss/cancel with less than 24 hours' notice a scheduled appointment three (3) times in twelve (12) consecutive months, it will be necessary for me to make arrangements to receive my medical care elsewhere.

I further understand that the policy works as follows:

- A telephone call to cancel the appointment is required the business day prior to the scheduled appointment to avoid a missed appointment fee.
- If one appointment is missed, a reminder letter will be sent indicating that a scheduled appointment has been missed.
- If a second appointment is missed, another reminder letter will be sent, and a $25 fee will be generated.
- Upon failing to keep a third scheduled appointment, a certified letter will be sent indicating that three (3) scheduled appointments have been missed. A $50 fee will be generated. Within thirty (30) days, I will no longer be able to receive care at SMG OB/GYN Lake Lansing and will need to make arrangements to receive medical care from another source. I further understand that SMG OB/GYN Lake Lansing will assist me in finding another Physician through referrals, but that effective thirty (30) days from the date of the certified letter and with my primary Physician's consent, I will be removed from the active Patient list of SMG OB/GYN Lake Lansing.

Please Note: Parents and/or legal guardians will be held responsible for the appointments of minor children. The current fee for a missed appointment is $25 to $80. Your insurance company will not cover this fee. You will not be able to be seen without payment of this fee.

I have read the above policy in its entirety and fully understand that the above information relates to me and to my family members.

_____ _____

Patient name (Please Print) DOB

_____ _____

Patient's Signature Date

SMG OB/GYN 1651 W. Lake Lansing Road T 517.253.3910
Suite 300 F 517.253.3911
East Lansing, MI 48823
901 S. Oakland Suite 102 T 989.227.3435
St. Johns, MI 48879 F 989.227.3436

SMG OB/GYN
Lake Lansing & St. Johns

Payment Policy

Patient Name: _____ DOB: _____
(PLEASE PRINT)

We participate with many insurance companies, however it is your responsibility to verify that your insurance covers care provided at Sparrow and by the providers at SMG OB/GYN.

Your charges will be billed direct to your insurance company. Your deductibles and copays are due at the time of your appointment. If your insurance requires prior authorization, you will need to obtain this information from your Primary Care Physician (PCP).

As we strive to work together toward your good health we need to communicate a clear understanding of our payment policy. Full payment is due at the time of service if your insurance programs does not participate with SMG OB/GYN. Arrangements must be made with the billing department in advance for any payment made for less than payment in full. We bill for services received during your visit. This includes procedures, obstetrical services and surgeries. Please understand that because your contract is between you and your insurance company, we are not responsible to know specific information about individual contacts.

If you have any questions, please call the billing department:

Billing Customer Service
Phone: 517.364.7999
800.221.0336
Monday – Friday, 8 a.m. to 5 p.m.

Thank you for your cooperation.

Patient Signature: _____ Date: _____

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Suite 300 F 517.253.3911
East Lansing, MI 48823
901 S. Oakland Suite 102 T 989.227.3435
St. Johns, MI 48879 F 989.227.3436

Sparrow

1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Communication with Family & Friends Involved in My Care or Payment of My Care

Patient's Name:_____ Birth date:_____

Patients may allow family and friends, such as spouse, parent(s), significant others, guardians or others, to call and discuss medical information, request prescriptions, obtain vaccine information, request test results, pick-up completed forms (i.e., FMLA, sport physicals), and have messages left on answering machines or voicemail. They may also designate an individual to accompany them to medical appointments.

Completion of this form authorizes the release of the information identified above, to the individuals indicated below.

This authorization may be revoked at any time by submitting a written request.

1. Name: _____ Phone #: _____ Relationship: _____

   I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

   (Please check all that apply)

   - ☐ Receive information regarding appointments, including dates & times, and to pick up completed forms
   - ☐ Discuss medical care or concerns including test results, prescriptions, and vaccines
   - ☐ Accompany patient to appointments
   - ☐ Other (describe) _____

2. Name: _____ Phone #: _____ Relationship: _____

   I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

   (Please check all that apply)

   - ☐ Receive information regarding appointments, including dates & times, and to pick up completed forms
   - ☐ Discuss medical care or concerns including test results, prescriptions, and vaccines
   - ☐ Accompany patient to appointments
   - ☐ Other (describe) _____

3. Name: _____ Phone #: _____ Relationship: _____

   I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

   (Please check all that apply)

   - ☐ Receive information regarding appointments, including dates & times, and to pick up completed forms
   - ☐ Discuss medical care or concerns including test results, prescriptions, and vaccines
   - ☐ Accompany patient to appointments
   - ☐ Other (describe) _____

I understand that the individual receiving my information is not a health care provider or health plan covered by state or federal privacy laws and regulations and that the information described above may no longer be protected by those laws and regulations.

I understand that I may revoke or change this authorization, in writing, at any time, by sending notification to the Sparrow Health Information Management at the address above.

_____ _____

Signature of patient Date & Time