SMG OB/GYN Lake Lansing – St. Johns

Returning 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? ____

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

Since your last visit have you had a change in any of the following? (please fill out only those that apply)

Medications? ( ) Yes ( ) No	Change:
Allergies? ( ) Yes ( ) No	Change:
Medical conditions or surgeries? ( ) Yes ( ) No	Change:
Family medical history? ( ) Yes ( ) No	Change:

Name: _______________________________________ Date of Birth: ___________Today's Date: _____________

Personal and Social History: Please tell us about yourself. This information is intended to help us understand and meet the varied needs of the people 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:	
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: ____	

Name: ____ Date of Birth: ____________Today's Date: ______________

*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:** ( ) Married ( ) Separated ( ) Unmarried / Single ( ) 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			

****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 <u>one</u> appointment is missed, a reminder letter will be sent indicating that a scheduled appointment has been missed.
- If a <u>second</u> appointment is missed, another reminder letter will be sent, and a $25 fee will be generated.
- Upon failing to keep a <u>third</u> 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
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St. Johns, MI 48879 F 989.227.3436

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