Sparrow Medical Group
Sparrow Women's Health
1200 E. Michigan, Suite 345, Lansing, MI 48912
Phone: (517) 364-5610 | Fax: (517) 364-5614

Patient Name: _____

Patient DOB: _____

MRN: _____

Welcome to Sparrow Women's Health

You are scheduled for an appointment in our office with:

Dr. _____ On _____ At _____ AM / PM

To help make your visit more efficient, please:

- Be **on time** for your appointment.
  - If you are 10 minutes late and/or your forms are not complete, we may have to reschedule your appointment.
  - If you unable to keep this appointment, please call us at least 24 hours in advance at (517) 364-5610.
- Bring a photo ID and all your insurance cards.
- Have all forms fully completed (front and back) before you come to your appointment.
- If you need an interpreter, please notify us at least one week before your appointment so we can make arrangements.

Will I see the same physician at every visit?

- The clinic has sixteen (16) resident physicians and three supervisors that work as a group.
- Due to their different shifts and schedules, some physicians will not be available in the clinic every week.
- **Please note**: the clinic has both male and female physicians that may be involved in your care and we cannot guarantee one or the other.

Location:

We are located in the Sparrow Professional Building, across from the main hospital, on the 3rd floor, Suite 345. Park in "***Parking Ramp C***"; ***please bring your parking ticket with you to every visit***.

Office Hours:	Monday – Friday	8:00 am – 12:00 pm	and	1:00 pm – 4:30 pm
Telephone Hours:	Monday – Friday	8:30 am – 12:00 pm	and	1:30 pm – 4:30 pm

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Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Referred to clinic by

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance:					

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

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PERSONAL INFORMATION (Ages 13 to Adult):

Name: _____ **Date of Birth:** _____

Primary Language: _____ **Occupation:** _____

Ethnicity: _____ **Race:** _____

Religion: _____

Marital Status (circle one): Married Single Divorced Widowed Separated Significant Other

First Day of LMP	**Number of Pregnancies**	**Number of Births:**

ALLERGIES: Please list all medication allergies and types of reactions

Medication Allergic to:	Type of Reaction:

MEDICATIONS: Please list **ALL** of your medications (including over the counter medications, vitamins, and supplements)

Medication Name	Medication Strength	How Often You Take the Medication	Who Prescribed the Medication

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PERSONAL MEDICAL HISTORY:

Please check the appropriate box for the following conditions that you currently have or have had in the past:

Allergies	Yes	No	Depression	Yes	No	Heart Attack(MI)	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Nerve/Muscle Disease	Yes	No
Anxiety	Yes	No	Emphysema/COPD	Yes	No	Osteoporosis	Yes	No
Arthritis	Yes	No	GERD (Reflux)	Yes	No	Seizures	Yes	No
Asthma	Yes	No	Glaucoma	Yes	No	Sickle Cell Anemia	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Substance Abuse	Yes	No
Cataracts	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Congestive Heart Failure	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Clotting Disorder	Yes	No	Meningitis	Yes	No	Ulcers	Yes	No

Other Past Medical History or important details of anything checked above:

PERSONAL SURGICAL HISTORY:

Appendectomy:	Yes	No	Cosmetic Surgery:	Yes	No	Joint Replacement:	Yes	No
Brain Surgery:	Yes	No	C-section:	Yes	No	Small Intestine Surgery:	Yes	No
Breast Surgery:	Yes	No	Eye Surgery:	Yes	No	Spine/Back Surgery:	Yes	No
CABG(Heart Bypass):	Yes	No	Fracture Surgery:	Yes	No	Tubal Libation:	Yes	No
Cholecystectomy (Gallbladder removal):	Yes	No	Hernia Repair:	Yes	No	Valve Replacement:	Yes	No
Colon Surgery:	Yes	No	Hysterectomy:	Yes	No			

Other Surgical History or important details of anything checked above:

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PERSONAL/SOCIAL HISTORY:

ALCOHOL USE:					Yes	No
Type:	Number Per **WEEK**					
Glasses of Wine:						
Cans/Bottles of Beer:						
Shots of Liquor:						
Other "Drinks":						
SEXUALLY ACTIVE:					Yes	No
Partners:					Male	Female
Method of Birth Control:						
DRUG USE/ABUSE:					Yes	No
Type:	Marijuana	Methamphetamine	Cocaine	IV	Prescription Meds	Other
TOBACCO USE:					Yes	No
Quit Date:					Passive Smoker	
Packs Per Day:	¼	½	1	1 ½	2	3 +

FAMILY HISTORY:

Were You Adopted? Yes No

	Status	**Adopted**	**Age:**	**Health Problems:**	**Cause of Death:**
MOTHER	Living / Deceased	Yes / No			
FATHER	Living / Deceased	Yes / No			
SISTER	Living / Deceased	Yes / No			
BROTHER	Living / Deceased	Yes / No			
SON	Living / Deceased	Yes / No			
DAUGHTER	Living / Deceased	Yes / No			
MATERNAL GRANDMOTHER	Living / Deceased	Yes / No			
MATERNAL GRANDFATHER	Living / Deceased	Yes / No			
PATERNAL GRANDMOTHER	Living / Deceased	Yes / No			
PATERNAL GRANDFATHER	Living / Deceased	Yes / No			

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REVIEW OF SYSTEMS:

Over the last three (3) months, have you been consistently bothered by any of the following symptoms:

Constitutional (General):

Activity Change	Yes	No
Appetite Change	Yes	No
Chills	Yes	No
Excessive Sweats	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Unexpected Weight Change	Yes	No

Genitourinary (GU):

Difficulty Urinating	Yes	No
Painful Urination	Yes	No
Incontinence	Yes	No
Flank (side) Pain	Yes	No
Frequent Urination	Yes	No
Genital Sores	Yes	No
Blood in the Urine	Yes	No
Urinary Urgency	Yes	No
Decreased Urination	Yes	No

Women Specific:

Pain During Intercourse	Yes	No
Menstrual Problems	Yes	No
Pelvic Pain	Yes	No
Unusual Vaginal Bleeding	Yes	No
Unusual Vaginal Discharge	Yes	No
Vaginal Pain	Yes	No

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Pregnancy History:

Number of Pregnancies		Number of Live Births		Number of Premature Births	
Number of Abortions		Number of Miscarriages		Number of Living Children	

#	MM / DD / YY of Birth	Birth Weight	Gender	# Weeks Pregnant	Type of Delivery and Name of Hospital	Complications?
1	/ /	Lbs. oz.	M F			
2	/ /	Lbs. oz.	M F			
3	/ /	Lbs. oz.	M F			
4	/ /	Lbs. oz.	M F			
5	/ /	Lbs. oz.	M F			
6	/ /	Lbs. oz.	M F			
7	/ /	Lbs. oz.	M F			
8	/ /	Lbs. oz.	M F			
9	/ /	Lbs. oz.	M F			
10	/ /	Lbs. oz.	M F			

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RELEASE OF MEDICAL INFORMATION

I hereby authorize medical information to be released to the following individual(s) upon request. If there is ***NO NAME LISTED BELOW***, we WILL NOT be able to release any information to anyone – including appointment date and time.

Name	Relationship	Phone

☐ I do not want to list anyone to call on my behalf.

NOTE: SIGNATURE IS REQUIRED BELOW EVEN IF NO ONE IS LISTED ABOVE.

I authorize Sparrow Women's Health to leave a detailed message on my answering machine or voicemail (i.e. blood test results, ultrasound results with instructions, information on referral to see a specialist, etc.)

Date	Patient Name	Date of Birth

Signature of Patient, Parent or Guardian

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MISSED APPOINTMENT POLICY

Welcome to Sparrow Women's Health

In order to provide quality care to our patients, improve access to and minimize waiting for appointments, our office has adopted the following "**Missed Appointment Policy"**:

I understand that if I should fail to keep a scheduled appointment three (3) times in a twelve (12) consecutive month period, it will be necessary for me to make arrangements to receive my medical care elsewhere.

I further understand that the procedure works as follows:

A telephone call made on the business day prior to the scheduled appointment is required to avoid a missed appointment fee.

If one appointment is missed, a reminder letter will be sent indicating that a scheduled appointment was missed.

If a second appointment is missed, another reminder will be sent.

Upon failing to keep a third scheduled appointment, a certified letter will be sent indicating that three (3) scheduled appointments have been missed. Within thirty (30) days, I will no longer be able to receive care at Sparrow Women's Health and will make arrangements to receive medical care from another source. I further understand that Sparrow Women's Health will assist me in finding another physician through referrals, but 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 within Sparrow Women's Health.

PLEASE NOTE: Parents and/or legal guardians will be held responsible for the appointments of minor children.

I have read the "Missed Appointment Policy" in its entirety and fully understand the information related to me and to my family members.

_____ _____

Patient/Parent Signature Witness Signature

_____ _____

Date Date