



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: _____

*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

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

Name of medication	Dose	Amount taken	How often
<i>Ex: Vitamin D</i>	<i>1,000 IU</i>	<i>1 tablet</i>	<i>Once daily</i>

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

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

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

Surgical History / Hospitalizations: Please list any surgeries or hospitalizations

Surgery/Hospitalization	Year	Surgery/Hospitalization	Year

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
<input type="checkbox"/> *Breast Cancer		<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> *Ovarian Cancer		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> *Uterine Cancer		<input type="checkbox"/> Emotional Issues	
<input type="checkbox"/> *Colon Cancer		<input type="checkbox"/> Mental Health Problems	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Alcoholism	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Birth Defects	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Other	

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 women 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 quitting? () 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, partner(s) are: () Male () Female () Both
*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

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

Menstrual History:

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

Post- menopausal Women: Please check all that apply Not applicable

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

Contraception: Please check any that apply

<input type="checkbox"/> IUD	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Partner had vasectomy	<input type="checkbox"/> Birth control Pill
<input type="checkbox"/> Patch, ring or implant	<input type="checkbox"/> Condoms	<input type="checkbox"/> None	<input type="checkbox"/> Other
<input type="checkbox"/> Natural Family Planning			

Gynecological History:

Have you ever had an abnormal pap test? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what year?
If yes, have you ever had a colposcopy? <input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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

****Last Menstrual Period Began? _____

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)

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: <input type="checkbox"/> Self Employed <input type="checkbox"/> Student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired (Retirement Date: _____)		
Primary Care Physician:						
MEDICARE PATIENTS ONLY- Please Answer the Following Questions:						
Are you eligible for black lung benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you entitled to benefits through the dept. of veteran's affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you on Medicare for an illness/injury that is due to a work-related accident/condition? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you eligible for Medicare based on disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you eligible for Medicare based on end-stage renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you or your spouse currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline			Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Decline			
Preferred Language: _____ Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No			How do you prefer to be contacted for preventive reminders? <input type="checkbox"/> MySparrow <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Do not contact			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/> Legally Separated <input type="checkbox"/> Significant other <input type="checkbox"/> 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 fail to keep 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

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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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: _____

Address: _____

Phone No.: _____

City/ST/Zip: _____

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. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's written or verbal consent.

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

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

I authorize representatives of Sparrow Health System and its affiliates to share and/or release my information to:

1. Name: _____ Phone #: _____ Relationship: _____
 Check all that apply:

- Regarding appointments, dates & times
- Discuss lab/test/x-ray results
- Discuss vaccines
- Discuss medical care, issues or concerns
- Request and pick-up completed forms
- Other (describe) _____

2. Name: _____ Phone #: _____ Relationship: _____
 Check all that apply:

- Regarding appointments, dates & times
- Discuss lab/test/x-ray results
- Discuss vaccines
- Discuss medical care, issues or concerns
- Request and pick-up completed forms
- Other (describe) _____

3. Name: _____ Phone #: _____ Relationship: _____
 Check all that apply:

- Regarding appointments, dates & times
- Discuss lab/test/x-ray results
- Discuss vaccines
- Discuss medical care, issues or concerns
- Request and pick-up completed forms
- 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.

 Signature of patient

 Date & Time