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

☐ Decline to Answer

*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.

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
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</tbody>
</table>
**Medications:** Please List ALL current medications including vitamins, herbs, and supplement’s

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Dose</th>
<th>Amount taken</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Ex: Vitamin D</em></td>
<td>1,000 IU</td>
<td>1 tablet</td>
<td>Once daily</td>
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</table>

**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

<table>
<thead>
<tr>
<th>Surgery/Hospitalization</th>
<th>Year</th>
<th>Surgery/Hospitalization</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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2/2023
**Family History:** If you check any of the following, please list relationship of the relative(s)


<table>
<thead>
<tr>
<th>Problem</th>
<th>Relationship</th>
<th>Problem</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) *Breast Cancer</td>
<td>( ) High Cholesterol</td>
<td></td>
<td></td>
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<tr>
<td>( ) *Ovarian Cancer</td>
<td>( ) Osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( ) *Uterine Cancer</td>
<td>( ) Emotional Issues</td>
<td></td>
<td></td>
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<tr>
<td>( ) *Colon Cancer</td>
<td>( ) Mental Health Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( ) Diabetes</td>
<td>( ) Alcoholism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( ) High Blood Pressure</td>
<td>( ) Birth Defects</td>
<td></td>
<td></td>
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<tr>
<td>( ) Heart Disease</td>
<td>( ) Other</td>
<td></td>
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</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>How is your general health?</th>
<th>( ) Good</th>
<th>( ) Fair</th>
<th>( ) Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have regular dental check ups?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td></td>
</tr>
<tr>
<td>Do you have any hearing problems?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td></td>
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<tr>
<td>Do you eat a healthy diet?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td></td>
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<tr>
<td>Do you exercise regularly?</td>
<td>( ) Yes</td>
<td>( ) No</td>
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<tr>
<td>*Do you do a monthly self breast exam?</td>
<td>( ) Yes</td>
<td>( ) No</td>
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<tr>
<td>Have you ever smoked cigarettes?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td></td>
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<tr>
<td>Do you still smoke?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td></td>
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<tr>
<td>Do you use smokeless tobacco?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td></td>
</tr>
<tr>
<td>Do you drink alcohol?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td>( ) In recovery</td>
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<tr>
<td>Type (ex. Wine, beer, liquor, etc.):</td>
<td></td>
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<tr>
<td>Do you use recreational drugs?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td>( ) In recovery</td>
</tr>
<tr>
<td>Type (Marijuana, cocaine, meth, etc.):</td>
<td></td>
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<tr>
<td>Have you ever been sexually active?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td></td>
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<tr>
<td>Birth control?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td>Type:</td>
</tr>
</tbody>
</table>
### Are you currently sexually active?
( ) Yes  ( ) No

If yes, during the past year my partner(s) are (check all that apply):
- ( ) Monogamous relationship with 1 man
- ( ) Monogamous 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:

<table>
<thead>
<tr>
<th>Age of first period?</th>
<th>Last menstrual period began?</th>
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</table>

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
Gynecological History:

<table>
<thead>
<tr>
<th>Have you ever had an abnormal pap test?</th>
<th>( ) Yes</th>
<th>( ) No</th>
<th>If yes, what year?</th>
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<tbody>
<tr>
<td>If yes, have you ever had a colposcopy?</td>
<td>( ) Yes</td>
<td>( ) No</td>
<td>If yes, what year?</td>
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<tr>
<td>Other treatment or procedures (ex. LEEP)?</td>
<td></td>
<td></td>
<td>What year?</td>
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<tr>
<td>Ever tested positive for a sexually transmitted disease (ex. Herpes, chlamydia, gonorrhea)?</td>
<td>( ) Yes</td>
<td>( ) No</td>
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</table>

If yes, list STD and Year:

Pregnancy History:

<table>
<thead>
<tr>
<th>Number of pregnancies</th>
<th>Number of live births</th>
<th>Number of premature births</th>
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<tbody>
<tr>
<td>Number of abortions</td>
<td>Number of miscarriages</td>
<td>Number of living children</td>
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</tbody>
</table>

Pregnancy History:

<table>
<thead>
<tr>
<th>Birth #</th>
<th>Month / Year of Birth</th>
<th>Weight</th>
<th>Gender</th>
<th>Weeks Pregnant</th>
<th>Type of Delivery</th>
<th>Complications</th>
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****Last Menstrual Period Began?__________________________
Review of Systems: Have you been experiencing any of the following problems?    ( ) No Problems

<table>
<thead>
<tr>
<th>General</th>
<th></th>
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<tbody>
<tr>
<td>( ) Chills</td>
<td>( ) Fatigue</td>
<td>( ) Fever</td>
</tr>
<tr>
<td>( ) Hot flashes</td>
<td>( ) Night Sweats</td>
<td>( ) Sleep disturbance</td>
</tr>
<tr>
<td>( ) Recent weight loss ____ pounds</td>
<td>( ) Recent weight gain ____ pounds</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Head, Eyes, Ear, Nose, and Throat</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>( ) Ear pain</td>
<td>( ) Hearing Loss</td>
<td>( ) Ringing in ears</td>
</tr>
<tr>
<td>( ) Congestion</td>
<td>( ) Nasal discharge</td>
<td>( ) Nosebleeds</td>
</tr>
<tr>
<td>( ) Sore throat</td>
<td>( ) Dental problems</td>
<td>( ) Vision problems</td>
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<table>
<thead>
<tr>
<th>Respiratory</th>
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<tbody>
<tr>
<td>( ) Shortness of breath</td>
<td>( ) Wheezing</td>
<td>( ) Cough</td>
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<thead>
<tr>
<th>Cardiovascular</th>
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<tbody>
<tr>
<td>( ) Chest pain</td>
<td>( ) Swelling</td>
<td>( ) Irregular heartbeat</td>
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<tr>
<td>( ) Heart palpitations</td>
<td>( ) Rapid heart rate</td>
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<thead>
<tr>
<th>Gastrointestinal</th>
<th></th>
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<tbody>
<tr>
<td>( ) Abdominal pain</td>
<td>( ) Bloody stools</td>
<td>( ) Constipation</td>
</tr>
<tr>
<td>( ) Diarrhea</td>
<td>( ) Nausea</td>
<td>( ) Vomiting</td>
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<table>
<thead>
<tr>
<th>Gynecology</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>( ) Pelvic pain</td>
<td>( ) Painful intercourse</td>
<td>( ) Vaginal discharge</td>
</tr>
<tr>
<td>( ) Painful periods</td>
<td>( ) Abnormal vaginal bleeding</td>
<td>( ) Nipple discharge</td>
</tr>
<tr>
<td>( ) Vulvar Itching</td>
<td>( ) Breast lump</td>
<td>( ) Genital ulcers</td>
</tr>
<tr>
<td>( ) Breast Pain</td>
<td>( ) Urinary frequency</td>
<td>( ) Painful urination</td>
</tr>
<tr>
<td>( ) Leaking Urine</td>
<td>( ) Nocturia (night urination)</td>
<td>( ) Urinary urgency</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>( ) Joint pain</td>
<td>( ) Joint stiffness</td>
<td>( ) Joint swelling</td>
</tr>
<tr>
<td>( ) Muscle pain</td>
<td>( ) Muscle weakness</td>
<td>( ) Limb pain / swelling</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Dermatological</th>
<th></th>
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<tbody>
<tr>
<td>( ) Acne</td>
<td>( ) Skin rash</td>
<td>( ) Mole changes</td>
</tr>
<tr>
<td>( ) Skin lesion</td>
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<table>
<thead>
<tr>
<th>Neurological</th>
<th></th>
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<tbody>
<tr>
<td>( ) Dizziness</td>
<td>( ) Headaches</td>
<td>( ) Numbness or tingling</td>
</tr>
<tr>
<td>( ) Weakness</td>
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<table>
<thead>
<tr>
<th>Psychological</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>( ) Anxiety</td>
<td>( ) Depression</td>
<td>( ) Decreased libido</td>
</tr>
</tbody>
</table>
Prenatal Diagnosis Screening Questionnaire

Patient:
Last Name: __________________________ First Name: __________________________ DOB: ______________

Father of Baby:
Last Name: __________________________ First Name: __________________________ DOB: ______________
Father’s Occupation: __________________________ and Education: __________________________

1. How old will you be when the baby is due? __________

2. Have you been diagnosed with phenylketonuria? ___ Yes ___ No

3. Have you, the baby’s father, or anyone in either family ever had the following?
   a. Down’s Syndrome ___ Yes ___ No
   b. Spina Bifida or Open Spine Defect ___ Yes ___ No
   c. Hemophilia ___ Yes ___ No
   d. Muscular Dystrophy ___ Yes ___ No

4. Do you or the baby’s father have any close relatives who have mental disabilities? ___ Yes ___ No
   If YES, describe: __________________________________________________________

5. Have you or the baby’s father had a child born dead or alive with a birth defect not listed in question #3.
   ___ Yes ___ No
   If YES, describe: __________________________________________________________

6. Do you, the baby’s father, or a close relative in either of your families have any inherited genetic or chromosomal diseases or disorders not listed above? ___ Yes ___ No
   If YES, describe: __________________________________________________________

7. Have you or a previous partner of this baby’s father had 3 or more spontaneous pregnancy losses? ___ Yes ___ No
   If YES, describe: __________________________________________________________

8. What race do you consider yourself? __________________________

9. Are either you or the baby’s father of Ashkenazi or Jewish heritage? ___ Yes ___ No
   If YES, have either of you been screened as carriers of Tay - Sachs disease? ___ Yes ___ No

10. If you or the baby’s father is African-American, have you been tested as a carrier for sickle cell trait? ___ Yes ___ No
    If YES, describe: __________________________________________________________

11. If you or the baby’s father is of Italian, Greek, or other Mediterranean heritage, have you been screened for anemia (Thalassemia)? ___ Yes ___ No
    If YES, describe: __________________________________________________________

12. If you or the baby’s father are Caucasian or Ashkenazi Jewish, have you been screened as cystic fibrosis carriers? ___ Yes ___ No
    If YES, describe: __________________________________________________________
Fee Schedule for Obstetrical Patients

Full Routine Obstetric Care, Vaginal Delivery CPT Code = 59400
Full Routine Obstetric Care, Cesarean Delivery CPT Code = 59510
Antepartum Care Only >7 visits CPT Code= 59426
Vaginal Delivery Only CPT Code= 50409
VBAC Only (Vaginal birth after previous cesarean) CPT Code= 59612
Cesarean Section Only CPT Code= 59514
Post-Partum Care Only CPT Code=59430

Most insurance plans pay for routine pregnancy visits, delivery, and delivery follow-up (post-partum) care with a single payment, known as a “global OB package fee.” What they consider as routine or normal, however, can vary from plan to plan.

Antepartum care is 13 visits. This includes the initial and routine subsequent history and physical exams, Patient’s weight, blood pressure, fetal heart tones, and routine urinalysis. Beginning with visit 14, evaluation and management codes will be billed, and there may be a copayment depending on your insurance coverage.

Please Note:
• Medical management of problems that are not related to pregnancy such as bladder, vaginal or lung infections, allergies, rashes, etc.- are billed separately as an office visit from the global OB package, the same way it would be if you had gone to an urgent care center or to your Primary Care Physician. Insurance covers them, but separately, and there may be a copayment, depending on your insurance plan.
• High-risk conditions in pregnancy that require greater evaluation and treatment than covered by your insurance plan may also need to be billed separately from a global fee. Examples of these could be diabetes or high blood pressure.
• Any special testing or medications received during the course of your pregnancy care is an additional charge. These charges are billed to your insurance carrier at the time of testing. They may include: Amniocentesis, non-stress testing, ultrasound, and genetics testing.
• We perform a 20-week ultrasound to verify your due date, screen for fetal anatomy, and location of the placenta. We feel this is an important test and recommend that you have this done. However, if there is no medical indication for this, it will be billed as a routine screening. Some insurance companies may or may not pay for this. Please check with your insurance company, if there is a medical indication we will use that diagnosis. The cost for the ultrasound is approximately $ 765.
Please notify us at once of any changes in your insurance carrier, coverage, or policy numbers. Please check with your insurance regarding any prior authorization requirements for your hospital stay. Failure to do so could adversely affect your insurance benefits for both Physician and hospital charges.

Prior authorization requirements are the responsibility of the Patient for all insurance carriers.

We DO NOT accept responsibility for this, regardless of what your insurance company may state.

__________________________  ____________________________
Patient name (Please Print)   DOB

__________________________  ____________________________
Patient’s Signature            Date

Sometimes an insurance plan requires additional documentation to approve payment for something done that is beyond the global OB package fee. Occasionally, they may initially refuse payment for these charges, and pass them on to you. If you have any questions or problems with your bill, or wonder what you might be responsible for in the future, please talk with our billing specialist, at 517.364.7999 or 855.221.0336. She also has voice mail for your convenience. We want to give you not only the best medical care we can during your pregnancy, but also the best experience.

Sincerely,

The providers and staff of
SMG OB/GYN Lake Lansing
SMG OB/GYN St. Johns
Ultrasound Payment Policy

Dear Patient:

We would like to advise you that most insurance companies will ONLY pay for one screening ultrasound (an ultrasound that is not ordered because of an identified problem) during a normal pregnancy. This policy is based on The American College of Obstetricians and Gynecologists (ACOG) practice Bulletin on Ultrasonography in Pregnancy and guidelines from the Society for Maternal-Fetal Medicine (SMFM). Any additional ultrasounds done, unless done for a very specific reason, may not be a covered benefit for you.

Under most insurance company guidelines additional ultrasounds ordered with a specific diagnosis should be a covered benefit, however, the final determination of coverage rests with your insurance carrier. If you are not sure what your insurance covers, please contact them.

********************************************************************************

My provider will discuss the reason(s) for requesting any additional ultrasound and advise me that it may or may not be a covered benefit for me under my insurance company’s benefit policy. I may elect to have this test and understand that if my insurance company denies coverage that I will be financially responsible for it.

__________________________   __________________________
Patient name (Please Print)     DOB

__________________________   __________________________
Patient’s Signature            Date
Sparrow Hospital Obstetrics and Maternity Care Services
Agreement for Hospital Care

At Sparrow Hospital’s Labor and Delivery Unit, we will do everything possible to give you the best care in your upcoming delivery. We provide:

- Obstetric care 24 hours a day, 365 days a year
- Experienced professionals that deliver thousands of babies every year
- A supportive environment during labor, birth, and after delivery

The doctors that may take care of you include: your personal Physician, other hospital Physicians, Resident Physicians, Nurses, Anesthesia Staff, and Pediatricians.

When you first come to the hospital, you will be seen by the Resident Physician who will evaluate you and call your personal physician group. If you are to be admitted to the hospital, a member of your personal physician group will be in charge of your care and present for your delivery. There will be times, though rare, when a member of your personal physician group may not be available for your delivery. If a member of your physician group is not available, Sparrow Hospital will provide another qualified obstetric physician to care for you.

**The doctors that will provide your care may be male. There is no guarantee that a female Physician will deliver your child.**

Your pregnancy and the birth of your baby will be one of the most exciting and emotional experiences of your lifetime. At Sparrow Hospital, we are honored to have the opportunity to share this wonderful event with you and your family. We are looking forward to meeting and caring for you!

I understand that the care provided to me by the staff of Sparrow Hospital Obstetrics and Maternity Care Services:

- May not always be the Physician that provided my prenatal care
- May include male Physicians

__________________________  __________________________
Patient name (Please Print)  DOB

__________________________  __________________________
Patient Signature  Date
Prenatal Infection Screening

Sparrow providers at SMG Lake Lansing OB/GYN follow guidelines and recommendations from The American College of Obstetricians and Gynecologist (ACOG) and the Michigan Department of Health and Human Services (MDHHS). That all pregnant patients undergo testing for HIV, Syphilis, Hepatitis B, Hepatitis C, Urine Drug Screen, Gonorrhea and Chlamydia with the first OB labs and again at 28 weeks. This is universal testing and not based on risk factors. If you don’t do these tests during pregnancy, your pediatrician may recommend additional screening and treatments for your newborn.

___________________________________________  _________________________
I agree to the recommended screening.                Date

___________________________________________  _________________________
I decline the recommended screening.                Date
**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**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>DOB</th>
</tr>
</thead>
</table>

**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 eligible for Medicare based on disability?  
  - Yes
  - No
- Are you or your spouse currently employed?  
  - Yes
  - No
- Are you or your spouse currently employed?  
  - Yes
  - No

**PRIMARY HEALTH INSURANCE & POLICY HOLDER INFORMATION**

- **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**

- **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:**
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
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: _________________
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: __________________

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