



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"/> *Breast 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?	*Whst 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: _____

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:	

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: _____



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Fee Schedule for Obstetrical Patients

Antepartum and normal vaginal delivery \$ 2,726
(\$1,122) (\$1,484) Post-Partum (\$233)

Antepartum and VBAC (Vaginal birth after previous cesarean) \$ 2,900
(\$1,122) (\$1,669) Post-Partum (\$233)

Antepartum and Cesarean Section \$ 2,912
(\$1,122) (\$1,674) Post-Partum (\$233)

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

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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 \$ 558.

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 carries. 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

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Missed Appointment Policy SMG OB/GYN Lake Lansing & St. Johns

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 Signature

Date

Patient Name (Printed)

Date of Birth

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Release of Medical Information Consent Form

SMG OB/GYN Lake Lansing and St. Johns may release any medical information to the following person(s). If there are no names written in this section we WILL NOT be able to release any information to anyone other than you.

Name Relationship

Name Relationship

Name Relationship

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

* * * * *

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

Patient name (Please Print)

Date of Birth

Patient's Signature

Date

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SMG OB/GYN Lake Lansing and 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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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)

Date of Birth

Patient’s Signature

Date

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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)

Date of Birth

Patient's Signature

Date

Witness Signature

Date

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