Patient Information:

Partridge Creek Obstetrics & Gynecology

LAST Name | FIRST Name | MI | Date of Birth / / | Age

- - | | | | |

SSN | Marital Status | Pharmacy | Location | Phone No.

Address | City | State | Zip

( ) | ( ) | ( )

Home Phone | Cell Phone | Work Phone

Indicate your primary method of contact: Cell Home Text Msg Email Work (circle one)

Email Address | Employer | ( ) Phone | Occupation

Primary Insurance Name:

Policy holder Full Name | Policy holder Employer | Policy holder D.O.B. | Relationship to patient

Secondary Insurance Name:

You will be asked to provide copies of all insurance cards, effective dates and policy holder information

Emergency Contact Person | ( ) Phone | Relationship

Who referred you to our office | Primary Care Physician

Authorization:

I authorize payment of insurance benefits to Partridge Creek Obstetrics & Gynecology. I agree that I shall be legally responsible for any medical or surgical charge incurred in the course of my treatment, including those that are applied to deductible, co-pay or non-covered/unpaid services. Accounts not paid within 30 days of the invoice date are subject to a **1.5%** monthly finance charge. Failure to pay for services rendered, your account may be turned over to a collection agency.

Release of Information:

I authorize Partridge Creek Obstetrics & Gynecology to release any and all medical information to my health insurance company necessary to process and pay any claim/claims.

Consent for Treatment:

I voluntarily consent to receive all such medical treatment that my medical provider considers beneficial to me. I understand that this care may include diagnostic tests, examinations, medical or surgical treatment. I am aware that the practice of Medicine is not an exact science and I hereby acknowledge that no guarantees have been made to me as to the results or treatment and exams provided.

Consent to Testing:

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues or products may be obtained and that tests will be performed upon such fluids, tissues and products including Human Immunodeficiency Virus (HIV, the virus that causes AIDS) as deemed appropriate by the provider and I consent to this.

You have the right to an Advanced Directive (Durable Power of Attorney for Health Care). Please check if you have the following:
[ ] Durable Power of Attorney for Health Care [ ] I don't have either, but would like more information [ ] I don't need that information

Signature of Patient or Legal Guardian **Date** **Witness Signature** **Date**

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Partridge Creek
Obstetrics & Gynecology

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

Medical History (any new from last visit): ☐ None

- ☐ Asthma
- ☐ Arthritis
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Stroke
- ☐ Epilepsy
- ☐ Migraines
- ☐ Lupus
- ☐ Emphysema
- ☐ Depression/Mental Illness
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Cholesterol
- ☐ Thyroid Disease: **Hyperthyroid**
- ☐ Thyroid Disease: **Hypothyroid**
- ☐ Ovarian Cysts
- ☐ Diabetes: **Type 1**
- ☐ Diabetes: **Type 2**
- ☐ Polycystic Ovaries (PCOS)
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Cancer (please specify type) _____
- ☐ Other: _____

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Female Partner ☐ Male Partner

Occupation: _____ Student: ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No ☐ Previously How many packs/cigarettes per day? _____

Do you use alcohol? ☐ Yes ☐ No ☐ Previously How many drinks per day/week? _____

Do you use drugs? ☐ Yes ☐ No ☐ Previously What kind? _____ How often? _____

OB/GYN History

First day of your last period: _____

Age of first period: _____ How many days between periods? _____ How long do your periods last? _____

Cramping during periods? ☐ Yes ☐ No Flow: ☐ Heavy ☐ Medium ☐ Light Clots: ☐ Yes ☐ No

Pain level during periods (1= mild 10= severe) _____ out of 10

Are you currently sexually active? ☐ Yes ☐ No

Is your current sexual partner(s)? ☐ Male ☐ Female ☐ Both

Are you currently pregnant? ☐ Yes ☐ No

Do you have a history of sexually transmitted diseases? ☐ Yes ☐ No Please specify type: _____

What are you currently using for contraception? ☐ None _____

What have you used previously? ☐ IUD ☐ Pills ☐ Condoms ☐ Patch ☐ Nuvaring ☐ Other: _____

Date of last pap smear: _____ ☐ Normal ☐ Abnormal Date of last mammogram: _____ ☐ Normal ☐ Abnormal

Date of last colonoscopy: _____ ☐ Normal ☐ Abnormal Date of last bone density: _____ ☐ Normal ☐ Abnormal

How many times have you been pregnant? _____ Number of children? _____

Date of delivery	Weeks at delivery	C-Section/Vaginal	Male/Female	Baby's birth weight	Complications

Surgical History (any new from last visit) ☐ None **Name:**_____

Date	Type of Surgery	Date	Type of Surgery

Medication (please include vitamins, over the counter medications) ☐ None

Medication	Dosage (mg, IU)	How often you take

Allergies (please include medications, environmental, and food allergies) ☐ None

Allergy	Reaction (hives, swelling, etc…)	Allergy	Reaction (hives, swelling, etc…)

Family Medical History (any new from last visit- please include relationship to you- i.e. parents, siblings, grandparents)

☐ Diabetes: **Type 1** _____
☐ Diabetes: **Type 2** _____
☐ High Blood Pressure _____
☐ Depression/Mental Illness _____
☐ Thyroid Disease: **Hypothyroid** _____
☐ Thyroid Disease: **Hyperthyroid** _____
☐ Kidney Disease _____
☐ Stroke _____
☐ Osteoporosis _____
☐ Lupus _____
☐ Heart Disease _____
☐ Emphysema _____
☐ Breast Cancer _____
☐ Colon Cancer _____
☐ Ovarian Cancer _____
☐ Other Cancer (please specify)
_____
_____
☐ Other (please specify)
_____
_____

Review of Symptoms (please mark any symptoms or problems you are experiencing today) ☐ No problems today

☐ Tired/Fatigue
☐ Loss of appetite
☐ Bleeding from gums
☐ Headache
☐ Chest pain
☐ Shortness of breath
☐ Shortness of breath with exercise
☐ Nausea
☐ Frequent urination at night
☐ Urinary Frequency
☐ Urinary Urgency
☐ Blood in Urine
☐ Joint Pain
☐ Loss of hair
☐ Memory/concentration difficulty
☐ Decreased libido (sex drive)
☐ Ringing in ears
☐ Vomiting
☐ Blood in stool
☐ Intolerance to cold
☐ Intolerance to heat
☐ Night sweats
☐ Decreased hearing
☐ Diarrhea
☐ Incontinence
☐ Anxiety
☐ Difficulty sleeping
☐ Weight loss
☐ Weight gain
☐ Lightheadedness
☐ Breast Lumps
☐ Breast tenderness
☐ Nipple discharge
☐ Constipation
☐ Hemorrhoids
☐ Heartburn

Concerns or problems you'd like to discuss today not listed above: _____

_____

Partridge Creek
Obstetrics & Gynecology

19991 Hall Road, Suite 105
Macomb, MI 48044

WELCOME TO OUR PRACTICE

As a service to you Partridge Creek Obstetrics & Gynecology participate with Medicare, Blue Cross and many insurance plans. We will submit claims to your insurance company for the medical service that has been provided to you. In the event your insurance claim is denied, you will be held responsible. It is important that you know what your insurance plan covers. Co-payments, deductibles and non-covered services must be paid in full at the time of service.

If your insurance is a Managed Care Plan or HMO, please review your coverage. If your visit requires a referral from your primary care physician (PCP) a copy of the referral form must be received by this office prior to your visit. Failure to obtain necessary authorization(s) often leads to delays or the need to re-schedule your appointment and out of pocket expenses. We are happy to assist you with your managed care plan, however, understanding your specific plan requirements and allowing adequate time to obtain authorization/referrals is essential.

Your physician is here to handle your medical care and well being. The physicians are not experts on insurance and are not always aware of financial arrangements made. Please discuss insurance and financial issues with the business office staff.

If you are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangements.

☐ **MEDICARE AUTHORIZATION** (check if applicable)

I request that payment of Medicare benefits be made to the Physician and or Physician associates providing services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that the payment be made and authorizes release of medial information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claims forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases the physician agrees to accept the charge determination of coinsurance, or non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

☐ **INSURANCE AUTHORIZATION** (check if applicable)

I request that payment of authorized benefits be made to the Physician or Physician associates for any services furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim (s).

I understand and accept the above statements

Signature of Beneficiary (Parent or Guardian) Date

Witness

We sincerely appreciate your cooperation and are happy to assist you in any way we can

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Partridge Creek
Obstetrics & Gynecology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative ("Agent") of the patient, acknowledges that he or she has been offered Partridge Creek Obstetrics & Gynecology, P.C.'s Notice of Privacy Policies on the date indicated below

_____ _____
Print name of patient Relationship to patient (if signed by agent)

_____ _____
Signature Date

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____, hereby authorize the physicians and staff of Partridge Creek Obstetrics & Gynecology, P.C. to give information concerning my health and well being to the following:

1- _____ _____ _____
Name Relationship Phone #

2- _____ _____ _____
Name Relationship Phone #

3- _____ _____ _____
Name Relationship Phone #

_____ I DO NOT authorize the release of my medical information to anyone

Confidential messages may be left at the following:

(such as appointment reminders, laboratory results, or medication information)

Home Voicemail ☐ Yes ☐ No Cellular Voicemail ☐ Yes ☐ No Work Voicemail ☐ Yes ☐ No

Text Message ☐ Yes ☐ No E-Mail ☐ Yes ☐ No

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, and who will be able to answer my questions:

Privacy Officer
19991 Hall Road, Suite 105
Macomb, MI 48044
586-247-8609

You as a patient have the right to:

1- Inspect and copy your medical information that may be used to make decisions about your care
2- Request an amendment to you medical record if you feel they are incorrect or incomplete. The physician may deny my request and notify me of the reason for his/her denial.
3- Request an accounting of disclosures. This is a list of disclosure for other then treatment, payment, or health care operations.
4- Request a restriction or limitation on the medical information used or disclosed about me for treatment, payment, or health care operations. All requests must be made in writing. However, the physician has the right to deny the restriction. If she/he does agree to the restriction, the office will comply with your request unless the information is needed to provide you with emergency care.

_____ _____
Print name of patient Relationship to patient (if signed by agent)

_____ _____
Signature Date

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