Sparrow Medical Group

We are unable to reschedule any new patient appointment that is not cancelled with 24 hour notice.

Matthew Allswede, M.D.
James Barton II, M.D.
Angela Griffin, M.D.
Jennifer Hawkins, D.O.
Kristin Koskela, M.D.
Valerie Levitt, M.D.
Donald McKeel, D.O.
Mary E. Pugmire, D.O.
Clara M. Regal, M.D.
Paul Schluckebier, M.D.
Martin Schoenmaker, M.D.
Amanda Gahsman, FNP-C
Mathew Vettathu, M.D.
Jenna Oesterle, DNP, FNP-C

Welcome to SMG Lansing OB/GYN Associates

Lansing Office
1200 E. Michigan, Ste 445
Lansing, MI 48912
P - (517) 364-5210
F - (517) 364-5216

Okemos Office
1600 W. Grand River
Okemos, MI 48864
P - (517) 381-6870
F – (517) 381-6871

This information packet includes: Patient information sheet, HIPAA Privacy Act, and a comprehensive health history form. Please use black ink to complete. A map is included on the backside of this form.

We encourage you to play an active role in your care by asking questions so informed decisions can be made.

Our office hours are Monday, Wednesday, Thursday and Friday, 8:00 a.m. to 5:00 p.m., and Tuesday 9:30 a.m. to 5:00 p.m. Be sure to let us know if you have ever been seen in our office before so we can include this medical history with your chart.

We work hard to see our patients in a timely fashion. Sometimes situations occur that make you wait longer that either of us would like. We will see you as soon as possible and provide you with all the necessary time for your exam and for answering questions and providing you with information to increase your understanding and comfort.

Please be sure to bring with you:

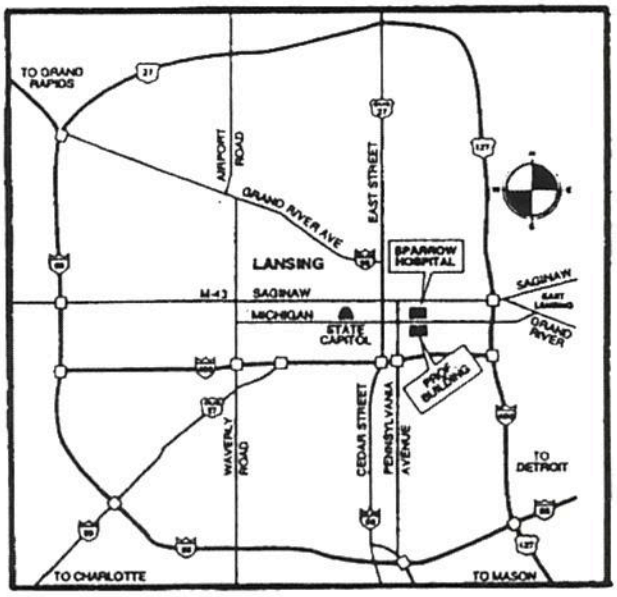
- **Insurance card (s) and all pertinent insurance identification**
- **Referral slip, if needed**

Please understand that there are over 1000 insurance plans in America. Therefore, it is impossible for our office to know the covered benefits of your specific plan. YOU are responsible for knowing and understanding the policies and benefits of your insurance plan.

THANK YOU FOR CHOOSING SMG LANSING OB/GYN

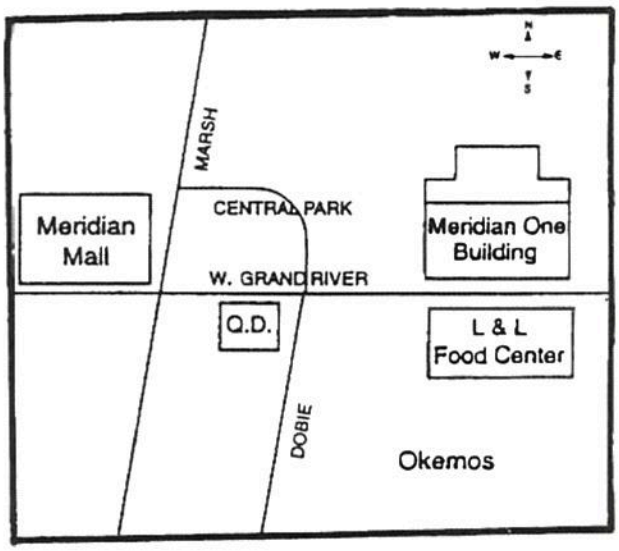
LANSING OFFICE
1200 E. Michigan Ave., Suite 445
Lansing, MI 48912
(517) 364-5210

Across from Sparrow Hospital



OKEMOS OFFICE
Meridian One Building
1600 W. Grand River
Okemos, MI 48864
(517) 381-6870

One mile east of the Meridian Mall, just past Dobie Rd. on the left.



PATIENT REGISTRATION INFORMATION

PLEASE PRINT LEGIBLY

PATIENT INFORMATION

Today's Date _____

Name _____ Date of Birth _____
First Middle Last

Address _____ SSN _____

_____ Home # (____)_____
City State Zip

Patient E-mail Address _____

Employer Name _____ Work # (____)_____

Employer Address _____ Cell # (____)_____

Employment Status: NO FT PT SE RET Military Approximate # of employees 1-19 20-99 100+

Marital Status: Single Married Divorced Widowed Separated Student Status: NO Full Time Part Time

Nationality or Cultural Origin _____ Religious Preference _____

Primary Care Dr (First and Last Name) _____ Who Referred You? _____

GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)

Name _____ Date of Birth _____
First Middle Last

Address _____ SSN _____

_____ Home # (____)_____
City State Zip

Work # (____)_____

Employer Name _____ Cell # (____)_____

Employer Address _____

Approximate # of employees 1-19 20-99 100+

Primary Insurance Information

Name of Insurance Company _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Policy # _____ Group # _____ Relationship to Patient _____

Subscriber's Employer _____ Approximate # of employees 1-19 20-99 100+

Subscriber's Employer Address _____

Secondary Insurance Information

Name of Insurance Company _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Policy # _____ Group # _____ Relationship to Patient _____

Subscriber's Employer _____ Approximate # of employees 1-19 20-99 100+

Subscriber's Employer Address _____

Emergency Contact Information

Name _____ Relationship _____

Address _____ Home # _____

Work # _____ Cell # _____

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

SMG LANSING OB/GYN PAYMENT POLICY

We participate with many insurance companies; however, it is **your** responsibility to verify participation with SMG Lansing 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 pre-authorization, you will need to obtain this information from your primary care physician.

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 for the insurance programs that we do not participate with. Any payment made for less than payment in full need to be made in advance, with the billing department. 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 contracts.

If you have any questions, please call our billing department at (517) 364-6200.

Thank you for your cooperation.

Signature: _____ Date: _____

Patient Signature

RELEASE OF MEDICAL INFORMATION TO INSURANCE COMPANIES

I authorize SMG Lansing OB/Gyn Associates to release to my insurance carrier (s); Information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance either to myself or to the party that accepts assignment.

I understand the provider's charge may exceed the payment made by my insurance and I agree to be responsible for the balance.

Signature: _____ Date: _____

Patient Signature

CONSENT FOR TREATMENT

I hearby authorize the SMG Lansing OB/Gyn physicians or designees to perform routine diagnostic procedures and medical treatment.

Signature: _____ Date: _____

Patient Signature

Sparrow

LANSING OB/GYN
NEW PATIENT HISTORY FORM

Name:_____ **DOB:** _____
(First) (Middle) (Last)

Reason for appointment: _____

Have you ever been seen at Lansing OB/Gyn? Yes / No If yes, when? _____

List any previous last name(s): _____

Who referred you to Lansing OB/Gyn? _____

Who is your primary care physician? _____

MEDICATIONS:

All current medications (please include vitamins, herbs, and supplements):

*For example: Vitamin D	1,000 IU	1 tablet	Once daily
Name of Medication:	**Dose:**	**Amount taken:**	**How Often:**

****Please attach list or use the back of this page if you have more medications than spaces**

ALLERGIES:

(medications, latex, iodine, peanuts, eggs):	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IMMUNIZATION HISTORY	Date of last vaccination month / day / year
Tetanus or Tdap (circle one)	____/____/____
MMR (Measles/Mumps/Rubella)	____/____/____
Influenza vaccine:	____/____/____
Pneumonia vaccine:	____/____/____
Chicken Pox (vaccine only):	____/____/____
Hepatitis B vaccine (3 injection dates):	____/____/____ ____/____/____ ____/____/____
Gardasil (HPV) Vaccine (3 injection dates):	____/____/____ ____/____/____ ____/____/____

RECENT TEST RESULTS:

Date	Name of Test	Results/Location
_____	Pap Smear	_____
_____	Mammogram	_____
_____	Bone Density Study	_____
_____	Colonoscopy	_____
_____	Pelvic Ultrasound	_____

GYN MEDICAL HISTORY

Are you having periods? Yes / No If No: why? _____

Age at first period: _____ Age at menopause: _____ or N/A

Do you have a history of abnormal pap smears? Yes / No

If yes, have you had a colposcopy? Yes / No If yes, when? _____

Treatment or procedures (i.e. LEEP) _____ Year: _____

Do you have a history of STD(s) (ie. herpes, chlamydia, gonorrhea, HPV)? Yes / No

If yes, list STD and year: _____

PAST MEDICAL HISTORY

***If yes, Please explain & list who manages this:

Anesthesia problems	**Yes**	**No**	_____
Blood clots/disorder	**Yes**	**No**	_____
Breast problems	**Yes**	**No**	_____
Cancer	**Yes**	**No**	**Type & Year:** _____
Chickenpox	**Yes**	**No**	**Age:** _____
Diabetes	**Yes**	**No**	_____
Heart disease	**Yes**	**No**	_____
Hereditary traits/defects	**Yes**	**No**	_____
High cholesterol	**Yes**	**No**	_____
High blood pressure	**Yes**	**No**	_____
Kidney / Bladder disease	**Yes**	**No**	_____
Liver disease	**Yes**	**No**	_____
Migraines	**Yes**	**No**	_____
Mood / Mental disorders	**Yes**	**No**	_____
Neurological problems	**Yes**	**No**	_____
Obesity	**Yes**	**No**	_____
Respiratory disease	**Yes**	**No**	_____
Stomach / Bowel disease	**Yes**	**No**	_____
Stroke	**Yes**	**No**	_____
Thyroid disease	**Yes**	**No**	_____
Other:	**Yes**	**No**	**List:** _____

PAST SURGICAL HISTORY(please do not include pregnancies)

Date	Procedure	Reason	Location	Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Please attach list or use the back of this page if you have more surgeries than spaces

FAMILY HISTORY

Has anyone in your family ever had any of the following:

***Please specify relationship: mother, father, brother, maternal grandfather, maternal grandmother, paternal grandfather, paternal grandmother, sister, brother, etc.(immediate family members only)**

Anesthesia problems	**Yes**	**No**	_____
Blood Clots/Disorders	**Yes**	**No**	_____
Cancer: Breast	**Yes**	**No**	_____
Uterine	**Yes**	**No**	_____
Ovarian	**Yes**	**No**	_____
Colon	**Yes**	**No**	_____
Other:	**Yes**	**No**	_____
Diabetes	**Yes**	**No**	_____
Heart disease	**Yes**	**No**	_____
Hereditary traits/defects	**Yes**	**No**	_____
High cholesterol	**Yes**	**No**	_____
High blood pressure	**Yes**	**No**	_____
Kidney disease	**Yes**	**No**	_____
Liver disease	**Yes**	**No**	_____
Mental Illness	**Yes**	**No**	_____
Neurological disease	**Yes**	**No**	_____
Obesity	**Yes**	**No**	_____
Osteoporosis	**Yes**	**No**	_____
Respiratory disease	**Yes**	**No**	_____
Stroke	**Yes**	**No**	_____
Other	**Yes**	**No**	**List** _____

PERSONAL/SOCIAL HISTORY

Do you drink alcohol? Yes / No

Amount per week: _____ **Type (i.e. wine, beer, liquer, etc):** _____

Do you use recreational drugs? Yes / No

Type: (i.e. marijuana, cocaine, meth, etc) _____

Last use (if applicable): _____ **How often?** _____

Have you ever smoked? Yes / No

If yes, do you still smoke? Yes / No If no, what year did you quit? _____

How long have you smoked? _____ **Amount per day:** _____

Have you ever been sexually active? Yes / No

Are you currently sexually active? Yes / No

If yes, are your partner(s): ___male ___female ___both

What form of birth control do you use (include male and female types)?: _____

Marital status (circle one):

Single Married Separated Divorced Widowed

Are you employed? Yes / No If yes, where? _____

Type of work: _____

Living arrangements (i.e. with spouse & children): _____

What is your primary language? English Other: _____

Highest Level of Education completed (circle one):

Grade: ____ High School Certificate Associates

Bachelors Masters Doctorate

Communication:

Visual impairment Yes / No If yes, describe: _____

Hearing impairment Yes / No If yes, describe: _____

Language barrier Yes / No If yes, describe: _____

Learning disability Yes / No If yes, describe: _____

Best learning method (circle one):

Written Verbal Demonstration/Visual Combination

Describe diet (i.e. healthy, diabetic, vegetarian, etc): _____

Do you drink caffeinated beverages daily? Yes / No

If yes, type: _____ **Amount:** _____

Do you exercise regularly? Yes / No

If yes, type: _____ **# of times per week** ____

Do you have a Durable Medical Power of Attorney? Yes / No

If no, would you like an information packet today? Yes / No

Do you perform monthly self-breast exams (circle one)?: **Yes / No**

Have you ever been physically, sexually or verbally abused? Yes / No

If yes, past or present relationship: _____

OB HISTORY

Please include ALL prior pregnancies

*Types of delivery: vaginal, C-section, miscarriage, termination, ectopic, VBAC, forceps, vacuum

**Problems include: group B strep, preterm labor, diabetes, preeclampsia, etc.

Year	Weeks (at delivery)	Type (of delivery)	Sex	Weight	Anesthesia	Location (of delivery)	Doctor	Problems
			M F					
			M F					
			M F					
			M F					
			M F					
			M F					

Sparrow
LANSING OB/GYN ASSOCIATES

MISSED APPOINTMENT POLICY
Lansing OB/Gyn

In order to provide quality care to our patients, improve access to and minimize waiting for appointments, 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 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, to cancel the appointment, is required the business day prior to the scheduled appointment to avoid a missed appointment fee.**
- **If <u>one</u> appointment is missed, a reminder letter will be sent indicating that a scheduled appointment has been missed.**
- **If a <u>second</u> appointment is missed, another reminder letter will be sent.**
- **Upon failing to keep a <u>third</u> 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 SMG Lansing OB/Gyn and will make arrangements to receive medical care from another source. I further understand that SMG Lansing OB/Gyn 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 Lansing OB/Gyn.**

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

There may be a fee charged for <u>any</u> missed appointment. The current fee for a missed appointment is $25.00 for an evaluation and management CPT code, and $80.00 for a complete physical.

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**

Sparrow

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