

Family Medical Center of Michigan

8765 Lewis Avenue • Temperance, MI 48182-9300 130 Medical Center Drive • Carleton, MI 48117-9029

Patient Data Sheet and Consent for Treatment

Child/Adolescent

Patient Name: _____ Age: _____ Male Female

Address: Street _____

City _____ State _____ Zip _____

Telephone Number: (____) _____ Date of Birth: _____

Social Security Number: _____ Mother's Maiden Name: _____

Race and Ethnic Background: Please check one. (Optional)

Black (Not Hispanic)

White (Not Hispanic)

Hispanic (All Races)

Asian/Pacific Islander

American Indian/Alaskan Native

Other

Mother's or Guardian's Name: _____ SSN: _____

Address: _____ DOB: _____

If different from above

Mother's or Guardian's Employer: _____ Phone: (____) _____

Address: _____

Street, City, State. Zip Code

Father's or Guardian's Name: _____ SSN: _____

Address: _____ DOB: _____

If different from above

Father's or Guardian's Employer: _____ Phone: (____) _____

Address: _____

Street, City, State. Zip Code

Party Responsible for the Bill: _____

Is parent a migrant farm worker: Yes No

Emergency Contact: _____ Phone: (____) _____

Address: _____

Street, City, State. Zip Code

I hereby request and authorize the staff of Family Medical Center of Michigan, using the facilities of the Family Medical Center of Michigan, to administer any treatment deemed necessary and advisable for my child's care until revoked in writing.

Signature: _____ Date: _____

I hereby request and authorize the staff of Family Medical Center of Michigan, using the facilities of the Family Medical Center of Michigan, to administer any treatment deemed necessary and advisable for my child's care, if I am unable to accompany my child, until revoked in writing.

Signature: _____ Date: _____

Signature: _____ Date: _____

Relationship to Patient: _____ Chart No.: _____

Family Medical Center of Michigan

8765 Lewis Avenue • Temperance, Michigan 48182-9300
130 Medical Center Drive • Carleton, Michigan 48117-9793

INSURANCE INFORMATION

Patient Name: _____

Primary Insurance: _____

Contract Number: _____ Group Number: _____

Policy Holder Name: _____

Secondary Insurance: _____

Contract Number: _____ Group Number: _____

Policy Holder Name: _____

I authorize Family Medical of Michigan to release any information necessary to process any medical claims for services provided to myself or family members covered by my insurance policy or required by regulatory or accrediting organizations.

I authorize payment of medical benefits be made directly to the Family Medical Center of Michigan.

Signature: _____ Date: _____

| | |
|--|---------|
| I understand that I will receive a statement of my account while my insurance is being billed, until it has been paid in full either by my insurance or by myself. | Initial |
|--|---------|

| | |
|--|---------|
| I understand that, if my insurance has not paid any claim within 45 days from the date of service that I am responsible for contacting my insurance company and/or paying the bill myself. | Initial |
|--|---------|

| | |
|---|---------|
| I understand that I am responsible for my charges at Family Medical Center of Michigan whether I am self-pay, receiving discounted services, or if my insurance does not pay for the charges incurred at Family Medical Center of Michigan. | Initial |
|---|---------|

Medical Record No. _____

Family Medical Center of Michigan, Inc.
About Our Notice of Privacy Practices

Family Medical Center is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information.
- how we may use and disclose the health information that we keep about you .
- your rights relating to your personal health information.
- our rights to change our Notice of Privacy Practices.
- how to file a complaint if you believe your privacy rights have been violated.
- the conditions that apply to uses and disclosures not described in this Notice.
- the person to contact for further information about our privacy practices.

Family Medical Center is required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have received a copy of Family Medical Center's Notice of Privacy Practices.

Patient's Signature

Date

Signature of Parent or Patient's Representative (if applicable)

Date

Description of Legal Authority to Act on Behalf of Patient

FAMILY MEDICAL CENTER OF MICHIGAN, INC. FINANCIAL POLICY

As a courtesy to our patients, Family Medical Center of Michigan will file your insurance claim with your primary insurance carrier. Family Medical Center of Michigan will supply you, upon request, with all pertinent information to assist in the filing of a claim to your secondary insurance carrier, or we will be glad to file those secondary insurance claims for you on a one-time basis.

To alleviate any misunderstandings regarding insurance payments, all patients must assign their primary insurance company directly to Family Medical Center. If you want the primary insurance company to pay you directly, Family Medical Center of Michigan will require full payment prior to services being rendered. Secondary insurance payments filed by Family Medical Center of Michigan must be assigned directly to Family Medical Center of Michigan. You will be responsible for all balances not covered by your primary or secondary insurance company.

Michigan law requires that insurance companies pay medical practices within a reasonable amount of time (45 days). If a problem persists, we will ask you to assist us in contacting your insurance carrier. Your insurance coverage is a contractual relationship between you and your insurance carrier, not Family Medical Center of Michigan and your insurance carrier (with the exception of managed care patients). Therefore, all claims not paid within a reasonable amount of time (45 days for "clean claims") will become your responsibility, for which you will receive a bill.

All patients must read and sign Family Medical Center of Michigan's written financial arrangement prior to services being rendered. Our staff will make every effort possible to clarify any misunderstanding that should occur concerning account balances.

Family Medical Center of Michigan's goal is to create an excellent physician/patient relationship.

Family Medical Center of Michigan uses the following guidelines regarding financial payment:

1. All patients must read and sign Family Medical Center of Michigan's financial agreement prior to services being rendered.
2. Insurance payments that have not been received within 60 days after filing will be turned over to the patient's responsibility.
3. The practice, at its sole discretion, may establish weekly/monthly payment arrangements to accommodate individual patient needs.

4. Patients will receive a statement of account each month indicating the amount that is the patient's responsibility. Payment of your balance is due within 30 days.
5. If you feel that your insurance company has not paid correctly, it is your responsibility to contact them.
6. Patients who do not remit payment in full will be turned over to a collection agency. Patients with payment arrangements must comply with their monthly payment plan. Failure to do so will result in turnover to collection agency.
7. Co-payments are required before services are rendered.
8. If you do not have insurance or have a sliding fee, payment in full is expected at time of service unless you have made prior payment arrangements with our patient accounts department.
9. If you have a delinquent account, you will be required to make a payment on your balance in addition to current service before services are rendered.
10. For patients who are eligible for Medicare, we are "Participating Physicians." This means that we must accept Medicare's allowed charge for the services rendered, eliminating the difference between what we charge and what Medicare approves. Medicare will send a check directly to our office for 80% of the approved amount. The patient is responsible for 20% of the approved charge, plus any deductible. If you have a secondary insurance, we will submit a claim to them once for any remaining balance after Medicare has paid. Please remember that although we will accept assignment for Medicare patients, the beneficiary, as required by federal law, is responsible for 20% of the approved amount and also for any routine services not covered by Medicare.
11. In cases of divorce, the parent seeking treatment is ultimately responsible for payment of the bill unless we receive legal documentation stating otherwise.

Date

Patient/or Responsible Party

FAMILY MEDICAL CENTER OF MICHIGAN, INC. HEALTH HISTORY

Patient Name _____ DOB ____/____/____

This history form provides us with information to help meet all your healthcare needs. Please complete all areas of this form by answering each question. **This is a confidential part of your medical record and will be kept secured in this office.**

General Information:

Today's date _____
 Place of birth _____
 Highest grade in school _____
 Occupation _____
 Previous occupation _____
 Marital status _____
 Hobbies _____
 Smoking: (type & amount per day) _____
 If former smoker, date quit _____
 Alcohol (type & amount per week) _____
 Caffeine (type & amount per day) _____
 Street drugs (type & amount per day) _____
 Usual weight _____ Ideal weight _____
 Date of last dental exam _____
 Please list all allergies (food, drug, environmental)

When was your last physical exam _____
 Name of doctor _____ Phone _____
 Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate the year these occurred:

Please list all medications you are currently taking (including nonprescription drugs)

Describe all serious accidents or surgeries (including date occurred)

Any history of family violence _____

Chief Complaint(s):

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Please circle the correct response:

| | | | | | | | | |
|-----------------|----|-----|-----------------------|----|-----|------------------------------|----|-----|
| Measles | No | Yes | Heart disease | No | Yes | Diabetes | No | Yes |
| Mumps | No | Yes | Arthritis | No | Yes | Cancer | No | Yes |
| Chickenpox | No | Yes | Venereal disease | No | Yes | Polio | No | Yes |
| Whooping cough | No | Yes | Anemia | No | Yes | Glaucoma | No | Yes |
| Scarlet fever | No | Yes | Bladder infections | No | Yes | Hernia | No | Yes |
| Diphtheria | No | Yes | Epilpsy | No | Yes | Blood or plasma Transfusions | No | Yes |
| Smallpox | No | Yes | Migraine | No | Yes | Back trouble | No | Yes |
| Pneumonia | No | Yes | headaches | No | Yes | High/low blood Pressure | No | Yes |
| Rheumatic fever | No | Yes | Tuberculosis | No | Yes | Hemorrhoids | No | Yes |
| Asthma | No | Yes | Bronchitis | No | Yes | Bleeding Tendency | No | Yes |
| Hives/Eczema | No | Yes | Mitral valve prolapse | No | Yes | Stroke | No | Yes |
| AIDS or HIV | No | Yes | Hepatitis | No | Yes | Ulcer | No | Yes |
| Infectious mono | No | Yes | Kidney disease | No | Yes | Thyroid disease | No | Yes |

Date of last Surgery _____

Any other diseases (please list) _____

Family History:

Has any blood relative had any of the following (Circle "no" or "yes", leave blank if uncertain)

| | No | Yes | Relationship | | No | Yes | Relationship |
|-------------------------|----|-----|--------------|--------------------|----|-----|--------------|
| Cancer | | | _____ | Depression | | | _____ |
| Tuberculosis | | | _____ | Psychosis | | | _____ |
| Diabetes | | | _____ | Suicide | | | _____ |
| Heart disease | | | _____ | Leukemia | | | _____ |
| High blood pres. | | | _____ | Migraine headaches | | | _____ |
| Stroke | | | _____ | Obesity | | | _____ |
| Epilepsy | | | _____ | Thyroid disease | | | _____ |
| Allergies | | | _____ | Ulcer | | | _____ |
| Anemia | | | _____ | High cholesterol | | | _____ |
| Bleeding tendency | | | _____ | Kidney disease | | | _____ |
| Asthma | | | _____ | Glaucoma | | | _____ |
| Chronic lung disease | | | _____ | Gout | | | _____ |
| Drug/Alcohol dependency | | | _____ | | | | |

List the present age of and health status (good, fair or poor); or the age of death and cause of death, of each of the following members of your family.

Father _____

Son _____

Mother _____

Daughter _____

Brother _____

Sister _____

Spouse _____

Medical History:

Do you now have or have you had within the past year:

| | | | | | | | | |
|-----------------------------|-----|----|-----------------------------------|-----|----|---------------------------|-----|----|
| Weakness or paralysis | Yes | No | Sore tongue or gums | Yes | No | Yellow jaundice | Yes | No |
| Tire easily | Yes | No | Breast lump or discharge | Yes | No | Frequent urination | Yes | No |
| Weight change | Yes | No | Chronic cough | Yes | No | Increase thirst | Yes | No |
| Change in appetite | Yes | No | Shortness of breath | Yes | No | Painful urination | Yes | No |
| Sensitivity to cold or heat | Yes | No | Bloody sputum | Yes | No | Leakage of urine | Yes | No |
| Persistent fever | Yes | No | Wheezing | Yes | No | Difficulty starting Urine | Yes | No |
| Night sweats | Yes | No | Chest pain/discomfort | Yes | No | Blood in urine | Yes | No |
| Hot flashes | Yes | No | Purple fingers/lips | Yes | No | Lack of sex drive | Yes | No |
| Skin rash | Yes | No | Swelling of hands, feet or ankles | Yes | No | Hemorrhoids | Yes | No |
| Skin problems | Yes | No | Difficulty breathing | Yes | No | Backaches | Yes | No |
| Change in nails or hair | Yes | No | Palpitations of heart | Yes | No | Joint pain | Yes | No |
| Headaches | Yes | No | Leg cramps | Yes | No | Swollen joints | Yes | No |
| Easy bleeding | Yes | No | Enlarged veins | Yes | No | Muscle cramps or Spasms | Yes | No |
| | | | Difficulty swallowing | Yes | No | Sleeplessness | Yes | No |
| | | | Heartburn | Yes | No | Seizures | Yes | No |

| | | | | | |
|-------------------------------------|-----|----|--------------------------------|-----|----|
| Easy bruising | Yes | No | Frequent belching | Yes | No |
| Double vision | Yes | No | Abdominal cramps | Yes | No |
| Blurred vision | Yes | No | Nausea | Yes | No |
| Eye pain | Yes | No | Vomiting | Yes | No |
| Infected eyes | Yes | No | Vomited or coughed up blood | Yes | No |
| Do you wear glasses or contacts? | Yes | No | Chronic diarrhea | Yes | No |
| Ringing in ears | Yes | No | Chronic constipation | Yes | No |
| Discharge from ears | Yes | No | Rectal bleeding | Yes | No |
| Ear pain | Yes | No | Black tarry stools | Yes | No |
| Hearing loss | Yes | No | Dark urine | Yes | No |
| Frequent nose bleeds | Yes | No | Depression | Yes | No |
| Frequent colds | Yes | No | Memory loss | Yes | No |
| Sinus problems | Yes | No | Poor Coordination | Yes | No |
| Loss of smell | Yes | No | Dizziness | Yes | No |
| Persistent hoarseness | Yes | No | Fainting | Yes | No |
| Sore throat | Yes | No | | | |

Men Only

| | | |
|------------------------------|-----|----|
| Discharge from penis | Yes | No |
| Pain or lump in testicles | Yes | No |
| Impotence | Yes | No |

Women Only

| | | |
|------------------------------------|-----|----|
| Age periods began | ___ | |
| # of days of last period | ___ | |
| Days between periods | ___ | |
| Is your flow heavy | Yes | No |
| Do you spot between periods | Yes | No |
| Do you have cramps | Yes | No |
| Date of last period | ___ | |
| Date of last pelvic Exam | ___ | |
| Date of last mammo | ___ | |
| Any itching in the Vaginal area | Yes | No |
| Pain with intercourse | Yes | No |
| Birth control | Yes | No |
| Number of births | ___ | |
| Miscarriages | ___ | |

Learning: I learn best by (check all that apply):

___ Reading ___ Video ___ Practice ___ Discussion ___ Demonstration

Who would you like to be involved in your teaching: _____
(spouse, family member, friend, other)

What information do you need about your illness/health? _____

Learning Concerns: _____
(language barrier, visual or hearing impairment)

To the best of my knowledge, the questions asked on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to notify this office of any changes in my medical status.

Signature _____ Date ___/___/___

Physician's Comments

Physician's signature _____ Date ___/___/___