Internal Medicine
560 W. Mitchell St. Ste 300
Petoskey, MI 49770
ph: 231.487.2460 fax: 231.487.6596

March 16, 2021

Traci Test
560 W. Mitchell
PETOSKEY MI 49770

Dear Traci

Thank you for choosing McLaren Northern Michigan Internal Medicine for your routine and specialized healthcare services. We recognize that you have choices for your medical care, and we appreciate you placing your confidence in us.

Our ten providers have over 120 years of combined experience and are proud to offer routine and specialized services, advanced diagnoses and treatments, consultations and access to clinical studies for our patients. We offer a variety of services to help meet your healthcare needs, including in-office draw station. A physician representing our practice is on-call twenty-four hours a day, seven days a week for urgent medical issues when the office is closed. A brochure is included with more information about our practice, or you may visit our website and patient portal at mclaren.org/northernim. In the event that hospitalization is required, patients of our practice will be attended to by a hospitalist at McLaren Northern Michigan.

We have reserved time for you as noted on the enclosed appointment card. The information enclosed will help to make your visit with us more productive. If you find it necessary to reschedule this appointment, please call us at 231.487.9702 (24 hours advance notice is requested). If your insurance is an HMO product, please contact member services at the number on the back of your insurance card to change your designated primary care physician.

To adequately prepare for your visit, we will need to receive and process clinical information into our system BEFORE your scheduled appointment. Please complete and return the questionnaire in the enclosed envelope. Sign and send the enclosed record release with cover sheet to your current healthcare provider so that past records are made available to us at least two weeks BEFORE your visit. If we do not receive the questionnaire and any pertinent records prior to your visit, your appointment could be cancelled. *See "Preparing for a Successful New Patient Visit" on the next page for more helpful hints.*

Again, thank you for choosing McLaren Northern Internal Medicine for your adult healthcare needs. We look forward to seeing you soon!

Sincerely,

Patient Services

Enclosures

Preparing for a Successful New Patient Visit:

<**BOLD** items below require your action>

- **The Authorization to Disclose Medical Information form should be completed, signed and forwarded to your previous doctor(s) or clinic(s) <u>with the instructional memo from our office</u>. This allows us to access records from your previous medical care, avoiding unnecessary duplication of tests or services.** You may copy this document if you require more than one form (for multiple providers).

  Please note that we only request certain items and will only keep those documents or data that are pertinent to your current medical care. You may want a complete copy of your past medical record for your future personal reference, which can be arranged with your former provider(s) by checking the box on the bottom of the cover memo to your previous healthcare provider.

- **Please complete the enclosed New Patient Questionnaire and Registration Form and mail them back in the enclosed envelope at least <u>two weeks</u> before your appointment. It may also be faxed to our office at 231.487.9746.**

- **Please arrive at least thirty minutes before your scheduled appointment time in order to complete the registration process.** You will be asked to present your insurance card(s) and current photo identification. If not already obtained, your social security number will also be collected and recorded in our system.
  Please be prepared to pay any co-pay charges or patient liabilities that might apply to your visit, as per the requirements of your insurance plan.

- **Please bring all your medications, including over-the-counter and nutritional supplements that you are taking.** To assure patient safety, we will verify your current medications at each and every visit to our office.

- **Please make a list of those topics you wish to discuss with the doctor.** This will make sure that your concerns are well known and that appropriate discussion occurs. We may ask you to specify those item(s) that are the highest concern for you to make the best use of your appointment time.

- If you are not able to keep this appointment, you may call scheduling at 231.487.9702 at any time to reschedule. After hours voicemail is available if you need to leave us a message after regular business hours.

- The enclosed material also includes phone numbers that you may use for future contacts with our office. For the convenience of our patients, our Triage Nurse staff are available during regular business hours and can be accessed by calling 231.487.9703. Activating your patient portal account will provide a secure method of ongoing communication and access to your healthcare data.

- Our practice now uses ePrescribe technology to manage prescription activity. Medication issues or refills can be communicated with your pharmacy provider, who will then contact us for refills or for clarifications as needed.

- Our in-office laboratory is available between the hours of 8:00 a.m. and 4:00 p.m., which means that you won't have make another appointment or go elsewhere if testing is required. Orders will be sent to other lab providers as requested.

- As a reminder and for the safety of others, we are a scent-free office. We ask that you avoid perfumes, colognes, or other scented products to help us maintain a scent-free environment.

- Ample free parking is available at the Burns Professional Building in access controlled lots. The front door staff can assist you as needed, and will provide shuttle service if requested.

- Our practice is conveniently located on the third floor of the Burns Professional Building, which is adjacent to McLaren Northern Michigan Hospital on West Mitchell/US 31 (just north of the intersection of US 131 and US 31).

- *Same-day appointments are usually available in our office for those with urgent needs. In the event that your doctor is unavailable, an appointment with another provider in our office may be offered.*

March 16, 2021

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All responses in this questionnaire are confidential and will become part of your medical record

NAME: Traci Test	SEX: Female	DOB: 01/27/1945
Marital Status: Single Partnered Married Separated Divorced Widowed		
Previous or Referring Doctor:	**Date of Last Physical Exam:**	

PERSONAL HEALTH HISTORY

Childhood Illness:	Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio		
Immunizations and Dates: (year if known)	Tetanus	Pneumonia	Other (please list):
	Hepatitis B	Chicken Pox	____________
	Influenza	MMR	____________
	Meningitis	HPV	____________
	Shingles	Pertussis/DTaP	____________

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion?... Yes No If Yes, what year

List Your Prescribed Drugs and Over-the-Counter Drugs, such as Vitamins and Inhalers*:		
Name of Drug	Strength	Frequency Taken

Allergies: **Latex** Dyes Seafood Eggs Other:

Medications Allergies*:

Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:	Sedentary (No exercise) Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.) Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)
Diet:	Are you dieting? .... Yes No If yes, are you on a physician prescribed medical diet? .... Yes No # of meals you eat in an average day? Rank Salt Intake Hi Med Low Rank Fat Intake Hi Med Low
Caffeine:	None Coffee Tea Cola # of Cups/Cans Per Day?
Alcohol:	Do you drink alcohol? .... Yes No If yes, what kind? How many drinks per week? Are you concerned about the amount you drink? .... Yes No Have you considered stopping? .... Yes No Have you ever experienced blackouts? .... Yes No Are you prone to “binge” drinking? .... Yes No Do you drive after drinking? .... Yes No
Tobacco:	Do you use tobacco? .... Yes No Cigarettes - Pks/day Chew - #/day Pipe - #/day Cigars - #/day # of Years or Year Quit Former smoker/tobacco user Never smoked or used tobacco Are you, or have you been, exposed to second-hand smoke? .... Yes No
Drugs:	Do you currently use recreational or street drugs? .... Yes No Have you ever given yourself street drugs with a needle? .... Yes No

*Use back of this page if additional space is needed

Are you sexually active?.. Yes No

If yes, are you trying for a pregnancy?... Yes No

If not trying for a pregnancy, list contraceptive or barrier method used

Any discomfort with intercourse?.. Yes No

Illness related to the Human Immunodeficiency Virus (HIV, such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness………………………………………………. Yes No

Personal Safety:

Do you live alone?.. Yes No

Do you have frequent falls?.. Yes No

Do you have vision or hearing loss?.. Yes No

Do you have an Advance Directive and /or Living Will?................................ Yes No

Would you like information on the preparation of these?............................... Yes No

Do you work with hazardous chemical or toxins?... Yes No

Are you exposed to chemical or irritants at work?... Yes No

Does your workplace have issues with excessive noise?.................................. Yes No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider ....Yes No

Family Health History

	Age or	Age at Death	Significant Health Problems or Cause of Death
Mother	________	________	________
Father	________	________	________
Siblings			
M / F	________	________	________
M / F	________	________	________
M / F	________	________	________
M /F	________	________	________
M / F	________	________	________
M / F	________	________	________

	Age or	Age at Death	Significant Health Problems or Cause of Death
Children			
M / F	________	________	________
M / F	________	________	________
M / F	________	________	________
M /F	________	________	________
Maternal Grandparents (Mother's Side)			
Male	________	________	________
Female	________	________	________
Paternal Grandparents (Father's Side)			
Male	________	________	________
Female	________	________	________

Family History of:

Diabetes?..Yes No

Heart problems?.. Yes No

High blood pressure of stroke?... Yes No

Aneurysm of circulatory problems?.. Yes No

Cancer?... Yes No

MENTAL HEALTH

Question	Yes	No
Do you feel safe at home?	Yes	No
Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY

Age at onset of menstruation: Date of last menstruation: Period every days.

Question	Yes	No
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No

Number of pregnancies Number of live births

Question	Yes	No
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean section?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No

Date of last pap smear and rectal exam? Date of last mammogram?

Date of last colonoscopy or sigmoidoscopy? Date of last bone density test?

MEN ONLY

Do you usually get up to urinate during the night? Yes No If yes, # of times

Question	Yes	No
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No

Date of last prostate and rectal exam? Date of last colonoscopy or sigmoidoscopy?

OTHER PROBLEMS (ROS)

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

General Weakness	Reproductive/Urinary	**Recent Changes In:**
Fatigue	Muscles/Joints/Bones	Weight
Eyes/Vision	Skin	Energy Level
Ear, Nose, Throat	Neurological/Psychiatric	Ability to Sleep
Heart/Circulation	Memory Problems	**Other Pain/Discomfort:**
Chest Pains	Dizziness	
Lungs/Breathing	Thyroid/Endocrine	
Stomach/Digestion	Blood/Lymphatic	

McLAREN HEALTHCARE

Authorization to Release Information

Traci Test 01/27/1945
Patient Name Birthdate

560 W. Mitchell PETOSKEY MI 49770 ______________________
Maiden/Other Names

I authorize ____________________ **to release to:** McLaren Internal Medicine
(name)

____________________ 560 W Mitchell St., Suite 300
(address)

____________________ Petoskey, MI 49770
(city, state, zip)

Fax: 231-487-9746

____
(telephone/fax)

Specific type of information to be disclosed: **Date(s) of Service**:___________

☐ Last 2 years ☐ History and Physical ☐ Physician's Notes ☐ Laboratory Results
☐ Diagnostic Imaging (e.g., X-Rays) reports from (date) ________________________
☐ Other ____

For the purpose of: ☐ Continuity of Care ☐ Transfer of Care

Sensitive information to be disclosed: **Date(s) of Service: ________________**
☐ Behavioral and Mental Health Service Information (excluding Psychotherapy Notes) ☐ Referrals and treatment for alcohol and substance use disorder ☐ Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

☐ **Consent to release Entire Medical Record, for dates of service listed, including all information noted above:**

Date(s) of Service: ________________________________
Initial **Date**

<u>Please complete second page of this form for acknowledgements and signatures that must accompany release.</u>

<u>Please complete this form for acknowledgements and signatures must accompany release.</u>

By signing this form I understand:

1. That I need not sign this form in order to ensure treatment, payment for or enrollment or eligibility for health benefits.
2. My health information may be shared electronically.
3. The sharing of my health information will follow state and federal laws and regulations.
4. This form does not give my consent to share psychotherapy notes as defined by federal law.
5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more that 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.
6. I should tell all agencies and people listed on this form when I withdraw my consent.
7. I can have a copy of this form.
8. That unless otherwise indicated or specified here, a request for disclosure of release of my "Entire Medical Record" or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, with includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
9. That any disclosure of information carries with it the potential for re-disclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.
10. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

____ _____________________

Signature of Patient or Legal Representative **Date**

____

If Signed by Legal Representative, State Relationship to Patient

____ _____________________

Signature of Witness Date

NOTE: PLEASE FORWARD A COPY OF THIS MEMO TO YOUR PREVIOUS HEALTHCARE PROVIDER(S) WITH THE SIGNED RELEASE AUTHORIZATION FORM

Medical Records Request for: Traci Test
DOB: 01/27/1945
560 W. Mitchell
PETOSKEY MI 49770
Phone:(231) 487-2460

Attached you will find an authorization signed by the above-named patient for release of medical information. While the authorization is all-inclusive, we are asking that only the following information be provided for the purposes of ongoing care for the patient at this time:

- Demographic Information/Face Sheet
- Problem/Surgery List
- Medication List with Known Drug Allergies
- Adult Flow Sheet/Preventative Medicine Overview (if available)
- Vaccination History
- Most recent Progress Note
- Most recent Physical Exam or H&P
- Recent Lab or Pathology reports (last 12 months)
- Recent Imaging Studies, including Ultrasounds (last 12 months)
- Most recent PAP result (if gender appropriate)
- Most recent Mammogram report (if gender appropriate, with any additional studies related)
- Most recent PSA (if gender appropriate)
- Most recent BMD study
- Most recent Colonoscopy report (and related biopsy reports if available)
- Most recent EKG (and any other cardiac studies completed if abnormal)

Note: We reserve the right to request more detailed information in the future, subject to the expiration of this authorization.

Please send the records to our EMR fax if the appointment occurs in a compressed time frame or if you intend on faxing the records requested (231-487-9746). Please note that this fax is for EMR medical records only and is on a secured server. If you need to communicate with our office for any other purpose, please use the correspondence fax at 231-487-6596.

Thank you for your assistance in this matter.

Sincerely,

Patient Services

Enclosure

McLaren Northern Michigan Internal Medicine
New Patient Registration

Patient Information:

Legal Name: ____ Date: _______________
Last First Middle Initial

Address: ____
Street City State Zip Code

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Social Security Number: _____-______-_____ Birth Date: _____/_____/_____ Sex: (M / F)

Email: _______________________________ Marital Status: Married / Single / Widowed /Divorce

Employed / Retired / Disabled / Not Employed

Insurance Information:

Primary Insurance: ____

Claims Address:____

Policy #: ____

Group #: ____

Policy Holder Name: ______________________ DOB: ________________

Patient Relationship to Policy Holder: ________________________________

Address: ____
Street City State Zip Code

Subscriber Employer____

Secondary Insurance Information:

Primary Insurance: ____

Claims Address: ____

Policy #: ____

Group #: ____

Policy Holder Name: ______________________ DOB: ________________

Patient Relationship to Policy Holder: ________________________________