***Welcome to Traverse Bay Internal Medicine!***

***Your designated Patient-Centered Medical Home***

**Phone: (231) 486-5516 Fax: (231) 421-1439**

The following is information that you will find helpful as you join our practice:

* We provide you with convenient 24/7 access to your medical records from the privacy of your computer or smart phone through our Patient Portal. (Secure login access)
* We follow the guidelines for Patient-Centered Medical Home (PCMH) to make sure you receive well-coordinated, effective care that addresses your concerns and respects your wishes.
* ***First Visit***: (print from our website) www. traversebayim.com /forms/New Patient Packet

 **Fill out** the Patient Registration and Medical History forms and bring them with you.

* 1. **Bring your insurance cards (required at every visit).**
	2. **Bring your driver’s license.**
	3. **Bring your current prescription bottles so we can record them accurately.**
	4. **Bring your vaccination history with you.**
	5. **Review your insurance coverage to determine your benefits** BEFORE **the appointment.**
	6. **Co-Pays and deductibles are due at the time of service.**
* ***Our Location and Hours*:**
* Address: 4977 Skyview Court, Traverse City, MI 49684
* Office Hours: Monday - Friday 8:00 a.m. to 5:00 p.m.
* Phone Hours: Monday - Friday 8:00 a.m. to 4:30 p.m. (closed 12:30 to 1:30 p.m.)

* Scheduling:
* Call 231-486-5516 or request an appointment through your patient portal to schedule.
* Please talk to the patient care coordinator to make appointments.
* Speak with the clinical staff to discuss current health concerns.
* Please call us if you are unable to keep your appointment.
* If you need to be seen urgently, we will try to schedule you for a same day appointment.
* After Hours:
* If you have an Emergent need, please call 911.
* If you have an urgent need, please call 231-486-5516 (press 1 to page the on-call provider).
* Prescription Refills:
* Please request your prescription refills at your office visits.
* Place refill requests through your pharmacy.
* Requests through the patient portal are preferred (login access required).
* We may take up to 24 hours to call in your refill—please plan accordingly.
* Financial Arrangements:
* See our Financial Policy for complete details.
* Charges not covered by your insurance are due at the time of service.
* You are fully responsible for any portion of your bill that is denied or otherwise not paid by your insurance carrier.
* Our billing office can work with you to set up a payment plan, if needed. Call 231-709-6196 to speak with one of our billing representatives.
* Once a claim has been sent to your insurance, we will not change the billing.

***Patient Information***

**Patient Name** *(First, MI, Last)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Preferred Name** *(e.g. “Bob” or “Pat”)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Former/Maiden Name** *(if applicable)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_

**Mailing Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number(s)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Home)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Work)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Cell)*

**Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex** *­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Spouses Name** *(If applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Do you have children? If so, names/ages**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Language** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Translator Needed?** *(Yes or No)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race** *(Circle One)* \*American Indian or Alaska Native \*Asian \*Native Hawaiian \*Other Race

 \*Black or African American \*White \*Hispanic \*Other Pacific Islander

**Ethnicity** *(Circle One)* \*Hispanic \*Non-Hispanic

***Additional Information***

**Employer Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Phone Number and Location** *(City, State)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Status** *(Full-time, Part-Time, Self-Employed, Retired, Other)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Retail Pharmacy Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Retail Pharmacy Address/Location** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Retail Pharmacy Phone Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mail Order Pharmacy Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mail Order Pharmacy Phone Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Social History***

**Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hobbies** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a place of worship?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you sexually active?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do you want to discuss protection?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco Use**  *(Please check the appropriate responses to the questions below)*

**Are you a :** □ Current Smoker □ Former Smoker □ Never Smoked

**If you are a current smoker, how often do you smoke?** □ Every Day □ Some days, but not every day

**If you smoke every day, how much do you smoke per day?** □ 5 or Less □ 6-10 □ 11-20 □ 21-30 □ 31+

**If you are a current smoker, are you: □** Ready to quit? □ Thinking about quitting? □ Not ready to quit?

**Alcohol Use** *(Please check the appropriate responses to the questions below)*

**Did you have a drink containing alcohol in the past year?** □ Yes □ No

**If Yes, how often did you drink in the past year?**□ Once per month or less □ 2-4 times per month

□ 2-3 times per week □ 4+ times per week

**If Yes, how many drinks did you have on a typical day when you were drinking in the past year?**

 □ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10+

**If yes, how often did you have 6 or more drinks on one occasion in the past year?**

□ Never □ Less than once per month □ Monthly □ Weekly □ Daily or almost daily

**Current Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Family History***

*(Please fill in the chart below)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Member** | **Status**(*Living or Deceased)* | **Age***(Current age if alive or age at time of death)* | **Health Conditions***(Please indicate approximate age of family member, if known, at onset of symptoms or diagnosis of disease)* |
| Father |  |  |  |
| Mother |  |  |  |
| Son(s) |  |  |  |
| Daughter(s) |  |  |  |
| Brother(s) |  |  |  |
| Sister(s) |  |  |  |
| PaternalGrandfather |  |  |  |
| PaternalGrandmother |  |  |  |
| MaternalGrandfather |  |  |  |
| MaternalGrandmother |  |  |  |

**Would you like information regarding available community resources and assistance programs?**

**If so, please list your interests/needs here** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medical History***

**Please list all of your current and past medical diagnoses**

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| --- | --- |
|  **Current Diagnosis**  |  **Past Diagnosis**  |
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**Current Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Surgical History***

**Please list all previous surgeries**

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| --- | --- |
|  **Date of Surgery**  |  **Surgeries Performed & Surgeon Name *(if known)*** |
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**Current Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Emotional Health***

**Please tell us about your current Emotional Health**

 ***Over the last 2 weeks, how often have you been bothered by any of the following problems?***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at All** | **Several Days** | **More Than Half of the Days** | **Nearly Every Day** |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed or hopeless |  |  |  |  |
| Trouble falling, or staying, asleep or sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or over-eating |  |  |  |  |
| Feeling bad about yourself, or that you are a failure or have let yourself, or your family, down |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| Moving or speaking so slowly that other people could have noticed, or (the opposite) being so fidgety or restless that you have been moving around a lot more than usual |  |  |  |  |
| Thoughts that you would be better off dead or of hurting  |  |  |  |  |

**Current Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Medications & Allergies***

**Please list all of your current medications with dosages**

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| **Medication List**  |
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**Please list any allergies** *(drug, food, environmental, etc.)* **and sensitivities** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medical Care Team***

**Name of Previous Primary Care Physician (PCP)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address/Location of Previous PCP** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number of Previous PCP** *(if known)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all other physicians you currently see** *(both in-state and/or out-of-state)*

|  |  |  |
| --- | --- | --- |
|  **Physician Name** |  **Location *(City, State)*** |  **Specialty** |
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**Do you currently leave the Traverse City area for the winter months** *(Yes or No)****?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes, what is the approximate month of your departure from Traverse City?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes, what is the approximate month of your return to Traverse City?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Immunization History***

**Please tell us about your immunization history if you have received vaccines outside of Michigan**

*\*Please list the approximate date you received each of the following immunizations*

*\*For immunizations you have not received, please tell us if the immunization was refused (Refused)*

|  |  |
| --- | --- |
| **Name of Immunization** | **Most Recent Immunization Date***(or Never or Refused)* |
| Pneumococcal (*Pneumovax)* |  |
| Pneumococcal (*Prevnar*) |  |
| Tetanus, Diptheria, Pertussis (*Td/Tdap*) |  |
| Influenza |  |
| Measles, Mumps, Rubella (*MMR)* |  |
| Shingles (*Zoster)* |  |
| Hepatitis B |  |
| Meningococcal |  |
| Chicken Pox (*Varicella*) |  |
| HPV |  |
| *Others (List below)* |  |
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**Authorization for the Use and Disclosure of Protected Health Information**

***Please complete the following and send to your previous physician***

**Release Records from:**

Name of former Physician or Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the above person or entity to release the following** (*Please select all that apply*):

\_\_\_\_\*My complete medical records

\**includes medical summary with current problem list, medications, and allergies, most recent EKG, latest H&P, last 1-year of lab/test results, consult and progress notes*

\_\_\_\_ Most recent Colorectal Cancer Screen (or documentation of Colectomy)

\_\_\_\_ Most recent Cervical Cancer Screen (or documentation of Hysterectomy)

\_\_\_\_ Most recent Breast Cancer Screen (or documentation of Mastectomy)

\_\_\_\_ Most recent Bone Density Test

\_\_\_\_ Most recent Diabetic Retinal Eye Exam

\_\_\_\_ Other (*Please specify)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the purpose of**: \_\_\_\_\_\_\_\_ Continuation of Care \_\_\_\_\_\_\_\_\_ Disability Determination

 \_\_\_\_\_\_\_\_ Legal Reasons \_\_\_\_\_\_\_\_\_ Other *(please specify, below)*

*(Specification of “other”)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Only the above-referenced information may be used and/or disclosed pursuant to this authorization

**Send Records to:**

**Traverse Bay Internal Medicine, P.C.** 4977 Skyview Court (231)486-5516 (Phone) Traverse City, MI 49684 (231)421-1439 (Fax)

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and submitted to the Privacy Officer at Traverse Bay Internal Medicine. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

This authorization expires upon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(insert date or event)*

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R 165.524).

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Traverse Bay Internal Medicine, nor will it affect my eligibility for benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Signature) (Date)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Name – Print) (Date of Birth)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *(Name of Personal Representative) (Relationship to Patient)*