Dr. Angela Pohl, DO
Dr. Caitlin Schmidt, DO

Traverse Bay Internal Medicine

Anne Zwart, PA-C
Amanda Gross, PA-C
Rikki Getz, PA-C

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.
  Bring your insurance cards (required at every visit).
  Bring your driver's license.
  Bring your current prescription bottles so we can record them accurately.
  Bring your vaccination history with you.
  Review your insurance coverage to determine your benefits BEFORE the appointment.
  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.

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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 _____

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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

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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)			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

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

If so, please list your interests/needs here _____

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Patient Name _____

Patient Date of Birth _____

Medical History

Please list all of your current and past medical diagnoses

Current Diagnosis	Past Diagnosis

Current Date _____

Patient Name _____

Patient Date of Birth _____

Surgical History

Please list all previous surgeries

Date of Surgery	**Surgeries Performed & Surgeon Name *(if known)***

Health Maintenance

	Normal/Abnormal	Date	NA or Unknown
Last Bone Density			
Last Conoloscopy			

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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 _____

Patient Date of Birth _____

Medications & Allergies

Please list all of your current medications with dosages

Medication List	

Please list any allergies *(drug, food, environmental, etc.)* **and sensitivities** _____

_____

_____

_____

Current Date _____

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**

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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Women's Health

Circle the symptoms that you're currently experiencing:

Vaginal discharge	Urinary Dysfunction	Sexual pain
Abnormal Menstrual Cycle	Decreased Libido	Headaches
Prolapse - Pelvic Support	Vaginal dryness	Mood Concern
Pelvic pain	Weight Concern	Hot flashes

Gynecologic History

Sexual/Physical/Emotional abuse history: (if yes are you safe now) _____

Specific gynecologic concerns? (Endometriosis/Fibroid/Infertility/PCOS/ Menopause)

_____
_____
_____

Have you ever had any cervical procedures *(please circle if applicable)*?

LEEP Conization Cryotherapy TCA

Last Menstrual Period (date): _____

History of Sexually Transmitted infections: _____

Are you currently using birth control? _____

Is there any additional information you would like to share regarding your gender identity?

_____

Current Date _____

Patient Name _____

Patient Date of Birth _____

Gynecologic History Continued…

	Normal/Abnormal	Date	N/A or Unknown
Last Papsmear			
Last Mammogram			

Obstetric History

□ I have never Been Pregnant

Pregnancies	Number
Vaginal Deliveries	
C-Section Deliveries	
Induced Abortion	
Spontaneous Abortion (Miscarriage)	
Ectopic Pregnancy	
Fetal Demise	

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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
Traverse City, MI 49684

(231)486-5516 (Phone)
(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)*