MEDICAL CLINIC OF NORTHVILLE

Patient Information

First Name:	M.I.	Last Name:		Today's Date:
Street Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Social Security Number:	
Date of Birth:	Age:	Sex(Circle One) M F	Spouse's Name:	Work Phone:
Employer:		Occupation (indicate if student):		
Street Address:		City:	State:	Zip Code:

Responsible Party (if other than patient)

First Name:	M.I.	Last Name:		Date of Birth:
Street Address:		City:	State:	Zip Code:
Home Phone:	Work Phone:	Social Security Number:	Employer:	
Employer Street Address:		City:	State:	Zip Code:

Miscellaneous Information

Referred By:		
Emergency contact not living with you:		Phone Number:
Would you like information on a living will?		

____ Yes ____ No

MEDICAL CLINIC OF NORTHVILLE

PERSONAL HISTORY

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Please list all allergies to food and medicine: _____

_____

Please indicate if you now have or have had the following medical conditions:

	No	Yes		No	Yes		No	Yes
Tuberculosis	___	___	High Blood Pressure	___	___	Diabetes	___	___
Chest Pain	___	___	Asthma	___	___	Hemorrhoids	___	___
Chronic Cough	___	___	Alcoholism	___	___	Glaucoma	___	___
Elev. Cholesterol	___	___	Headaches	___	___	Heart Attack	___	___
Edema	___	___	HIV/AIDS	___	___	Obesity	___	___
Bleeding Disorders	___	___	Cancer	___	___	Venereal Disease	___	___
Seizures	___	___	Constipation	___	___	Kidney Stones	___	___
Rheumatic Fever	___	___	Arthritis	___	___	Thyroid Disorders	___	___
Injuries	___	___	Emotional (Nerves)	___	___	Hepatitis/Jaundice	___	___

Other _____

_____

List all medications (prescriptions and over the counter) you are currently taking (dosage & frequency):

_____

_____

_____

My last tetanus shot was: _____ Flu Shot: _____ Pneumovax: ___ Other: __

I exercise (type and frequency): _____

I wear seat belts while driving or riding: ___ Always ___Usually ___ Often ___ Occasionally ___ Never

I drink caffeinated beverages (coffee/soda) ___ Always ___ Usually ___ Often ___ Occasionally ___ Never

Do you smoke? ___ No ___ Yes # of packs per day? _____ # of years you have smoked? _____

Do you drink any type of alcoholic beverage? ___ No ___ Yes

If yes, please indicate the number and type (cans, glasses, bottles) of drinks per week _____

Do you use any type of street drugs (i.e. marijuana, cocaine, etc.) ___ No ___ Yes

If yes, please list _____

Reviewed by:

_____ Dr.	_____ Date		_____ Dr.	_____ Date		_____ Dr.	_____ Date	
_____ Dr.	_____ Date		_____ Dr.	_____ Date		_____ Dr.	_____ Date	
_____ Dr.	_____ Date		_____ Dr.	_____ Date		_____ Dr.	_____ Date	
_____ Dr.	_____ Date		_____ Dr.	_____ Date		_____ Dr.	_____ Date	
_____ Dr.	_____ Date		_____ Dr.	_____ Date		_____ Dr.	_____ Date	

(Please turn page over and complete back side of form)

List previous hospitalizations/surgeries:

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Men: Last testicular exam _____ Last prostate exam _____

Women: Age at first period _____ Date of last period _____

Family history of breast cancer? ___ Yes ___ No

List any problems associated with periods or pregnancies _____

_____

List number of pregnancies _____ miscarriages _____ abortions _____

Type of birth control used _____

Last pap was (month/year) _____ Where done _____

Last mammogram was (month/year) _____ Where done _____

FAMILY HISTORY

Please indicate any of the following medical problems within your family history:

M = Mother F = Father S/B = Sister or Brother
PG = Paternal Grandparent MG = Maternal Grandparent A/U = Aunt or Uncle

	M	F	S/B	PG	MG	A/U
High Blood Pressure						
Allergy/Asthma						
Heart Attack						
Diabetes						
Elevated Cholesterol						
Cancer Type:_____						
Arthritis						
Kidney Stones						
Bleeding Disorders						
Stroke						
Obesity						
Alcoholism						
HIV/AIDS						
Glaucoma						
Seizures						
Thyroid Disorders						

Medical Clinic of Northville
308 S. Main Street
Northville, MI 48167

Today's Visit

Date: _____

Main reason for today's visit:

_____

_____

_____

Check all that apply:

- ☐ Review labs/or test results
- ☐ I have prescriptions that need to be refilled
- ☐ I need a school or work excuse
- ☐ I need a referral for my insurance company
- ☐ I need the attached forms filled out

Patient's Name: _____

Patient's Date of Birth: _____/____/_____

Any change in personal health history since last visit?

_____

_____

Any change in family health history since last visit?

_____

_____

Any new medication prescribed by another physician?

_____

_____

MEDICAL CLINIC OF NORTHVILLE
Privacy Policy Acknowledgement

I have been given a copy of the Notice of Privacy Policy for Medical Clinic of Northville. This is to certify that I have read and understand these policies.

Signature	Print Name	Date

I understand the contents of the Notice of Privacy Policy, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Messages regarding appointments with this office may be left on my home answering machine or with persons answering my home phone: _____ No _____ Yes

Messages regarding test results may be given someone other than myself:

___ No ___ Yes If yes, whom may we speak to: _____

I request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply. If not signed by patient, please indicate relationship to patient (i.e. spouse or parent)

Signature	Print Name	Date

Relationship	Witnessed By

Internal Use Only:

If patient or patient's representative refused to sign acknowledgement of receipt of Notice of Privacy Policy, please document the date and time the Notice was presented to the patient and sign below.

Signature	Date

GENERAL CONSENT TO TREATMENT

PATIENT NAME: _____

1. REQUEST AND CONSENT TO AMBULATORY SERVICES.

By signing this form, I am requesting and consenting to the ambulatory and office services as the physician or his designees ("physician") believe necessary for the patient. These services include, without limitation, routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs, and routine medical, nursing and ambulatory care. I know that in emergencies the physician may believe it necessary to expand or deviate from these services. I request and consent to these expanded and/or different services and procedures as the physician may think best for the health of the patient. I also consent to the Medical Clinic of Northville personnel doing the things they would normally do in caring for a patient, and as instructed by the physician. I understand that the Medical Clinic of Northville may perform non- diagnostic tests on the patient's blood, urine and other bodily fluids/tissues that were drawn for diagnositic purposes, and the Medical Clinic of Northville may dispose of these specimens as it chooses. I understand that General Consent to Treatment (entire form) will remain in effect until such time as I cancel (revoke) it in writing.

2. NO GUARANTEES.

I understand that medicine is not an exact science and that diagnosis and treatment involve risks. No one can or has given me a guarantee or promise of what the results of the patient's diagnosis, treatment and care will be.

3. HUMAN IMMUNODEFICIENCY VIRIS (HIV) TESTING.

I understand that the Medical Clinic of Northville may perform an HIV test upon the patient without any special written consent if a health professional or employee of the Medical Clinic of Northville has a percutaneous, mucous membrane, or open wound exposure to the patient’s blood or other body fluid.

4. RELEASE OF INFORMATION.

I authorize the Medical Clinic of Northville to release information from the patient's medical record, including:

a) Information about communicable diseases and serious communicable diseases and infections as defined by statue and Michigan Department of Public Health Rules, (which include venereal disease "VD", tuberculosis "TB", human Immunodeficiency virus "HIV", acquired immunodeficiency syndrome" AIDS", and AIDS related complex" ARC".

b) substance abuse treatment information protected by 42 Code of Federal Regulations Part 2.

c) psychological and social services information including communications made by me to a psychologist or social worker to:

   1) any, third party payer or insurance company (including Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workel"s' disability compensation insurers, health maintenance organizations, preferred provider organizations, and managed care plans) which are responsible in whole or in part for paying my Medical Center bill so that the Medical Center may be paid for its services; and/or
   2) any health care facility or physician to which I am referred or transferred for continuity of care; and/or
   3) any independent auditors or reviewers retained by any third party payer, private health insurer or any employer providing health insurance benefits to me so that these independent auditors can analyze Medical Clinic charges; and/or
   4) any party retained by Medical Clinic of Northville to provide accounting, billing or collection services to Medical Clinic of Northville and parties to whom I may be referred to assist me in obtaining third party reimbursement for treatment, services and procedures rendered to me.

This release authorization shall be effective only so long as it is necessary to accomplish the purpose for which it is given. In regards to substance abuse information (if any), this consent may be revoked at any earlier time unless the Medical Clinic of Northville has already released information in reliance upon it.

5. PAYMENT PROVISIONS

NOTE: The term "health care benefits" in the following paragraphs means Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurance benefits, automobile no-fault benefits, workers' disability compensation benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

a) I understand that, except in limited circumstances, separate billings will be issued for services of the Health Center and services of physicians, and that neither charges are included in the billings of the other.
b) I request payment on the patient's behalf of all health care benefits for services provided by the Health Center and by physicians for whom the Health Center is authorized to bill.
c) I assign and transfer to the Health Center all health care benefits applicable to the patient's care, including those health care benefits listed on the first page of my medical record. I authorize and direct that all such health care benefits be paid directly to the Health Center.
d) I agree personally to pay for any Health Center or physician charges not covered by or collected from any applicable health care benefit program, including any deductibles and coinsurance amounts.

I have read and understand this form, and consent to it. If the signer is not the patient, the signer certifies that he/she is the patient's legally authorized representative.

_____ _____

Signature of Patient or Patient Representative Date

MEDICAL CLINIC of NORTHVILLE

308 S. Main Street
Northville, MI 48167

To help us plan for advertising, please let us know how you were referred to our facility. Your help is greatly appreciated!

Your city of residence: _____
(This is used only to help us plan where to advertise - it is not shared with anyone)

You were referred to our practice by (please check all that apply):

[ ] Family Member

[ ] Friend/Co-Worker/Neighbor

[ ] Yellow Pages (internet)

[ ] Yellow Pages (phone book)

[ ] Hometown Directory

[ ] Insurance Directory (internet)

[ ] Insurance Directory (paper or book listing)

[ ] Internet (other than yellow pages or insurance directory)

[ ] Printed Media (Newspaper/Flyer)

[ ] Professional (Physician/Dentist/Lawyer/Etc.)

[ ] Pharmacy

[ ] Drive By

[ ] You were a previous patient

[ ] Other _____

Thank You!
The Staff at Medical Clinic of Northville

MEDICAL CLINIC OF NORTHVILLE

Ross A Summers, M.D.
Cheryl A. Johnstone, M.D.
Amy L. Berke, M.D.
Mirella F. Ducu, M.D.

NORMAL, REPEAT & CRITICAL VALUES

Results of critical value are called to the attention of the ordering physician as soon as possible. Critical values are reported to the ordering physician during normal office hours. All such calls are to be documented.

WAIVED TESTING

TEST	NORMAL	REPEAT	CRITICAL	UNITS
Blood Glucose (Fasting)	74-106	≥ 200	≥ 200	mg/dL
Blood Glucose (Non-Fasting)	70-140	≥ 200	≥ 300	mg/dL
Urine hCG (Non-pregnant)	Negative	NONE	NONE	NONE
Urine hCG (Pregnant)	Positive	NONE	NONE	NONE
URINALYSIS DIPSTICK				
Leukocytes	Negative	NONE	NONE	NONE
Nitrate	Negative	NONE	NONE	NONE
Urobilinogen (Male)	≤ 2	NONE	NONE	EU
Urobilinogen (Female)	≤ 1	NONE	NONE	EU
Protein	0--20	NONE	NONE	mg/dL
pH	5.0 - 8.0	NONE	NONE	NONE
Blood	Negative	NONE	NONE	NONE
Specific Gravity	1.003-1.029	NONE	NONE	NONE
Ketones	Negative	NONE	NONE	NONE
Bi lirubin	Negative	NONE	NONE	NONE
Glucose	≤ 30	NONE	NONE	mg/dL
Mononucleosis	Negative	NONE	NONE	NONE
Influenza A & B	Negative	NONE	NONE	NONE
Strep A Screen	Negative	NONE	NONE	NONE
Hemoccult	Negative	NONE	NONE	NONE
ESR (Sed Rate) (Male >50)	≤ 20	NONE	NONE	mm/hr
ESR (Sed Rate) (Male <50)	≤ 15	NONE	NONE	mm/hr
ESR (Sed Rate) (Female >50)	≤ 30	NONE	NONE	mm/hr
ESR (Sed Rate) (Female <50)	≤ 20	NONE	NONE	mm/hr
ESR (Sed Rate) (Children)	≤ 13	NONE	NONE	mm/hr
ESR (Sed Rate) (Newborn)	≤ 2	NONE	NONE	mm/hr

HEMATOLOGY

TEST	NORMAL	REPEAT	CRITICAL	UNITS
WBC	4.1 - 10.9	< 3.5 or > 13.0	< 2.5 or > 30.0	K/uL
HGB	12 - 18	< 10 or > 18	< 8 or > 18	g/dL
Platiet	140 - 440	< 100 or > 500	< 50 or > 999	K/uL
RBC	4.2 - 6.3	< 3.0 or > 7.0	None	M/uL
HCT	37 - 51	< 35 or > 55	None	%

308 S. Main Street
Northville, MI 48167

(248) 349-1900
fax (248) 349-3195

Medical Clinic of Northville

Recommendations

Our clinic is in the process of enhancing our current organization of your care. Please help us improve the quality of your medical care by providing us with updated information, as appropriate. We will need to request these records from the appropriate source, so please also indicate where you had the screening done.

If you do not know the exact date, please give us an **ESTIMATE of when you believe it was completed

	Date	Location/Provider where completed
For all patients		
Tetanus Vaccine	_____	_____
Influenza Vaccine	_____	_____
For all Females		
Mammogram	_____	_____
PAP smear	_____	_____
For ages 50 and older		
Colonoscopy *or* stool occult *or* sigmoidoscopy (please circle which one)	_____	_____
Shingles Vaccine	_____	_____
Pneumonia Vaccine	_____	_____
For Diabetics		
Diabetic Eye Exam	_____	_____
Foot exam	_____	_____

If you have records at home, bring those at your next appointment to complete this form

Printed Name _____ DOB_____

Signature _____ Date _____

Ethnicity _____ Preferred Language _____ Defer Response_____