WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help you.

1. Patient Information

Date_____

First Name:_____ Last Name:_____ Maiden Name: _____

Address:_____City:_____ State:_____Zip:_____

Date of Birth:_____/_____/_____ Social Security #_____ Email Address: _____

Primary Phone #: _____ Secondary Phone #: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced **Sex:** ☐ Male ☐ Female

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Caucasian ☐ Other ☐ Pacific Islander ☐ Declined

Ethnicity: ☐ Non-Hispanic ☐ Hispanic **Language:**_____ **Are you a Veteran:** ☐ Yes ☐ No

Employer: _____ Employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed

Employer Address: _____City:_____State:_____Zip:_____

If Patient is a Minor:

Mother's Name:_____

Mother's Phone #: _____

Father's Name:_____

Father's Phone #: _____

Family Information:

Please list all family members that are patients at our office.

Relationship	Name	DOB	Contact #

2. Responsible Party

Who is responsible for the bill? If same as above, check here: ☐

Name:_____

Relationship to patient:_____

Birthdate:_____/_____/_____

Driver's License#_____

Social Security#:_____

Address:_____

City, State, Zip:_____

Employer:_____ Occupation:_____

Work Ph:(___)_____Home Ph:(___)_____

3. Emergency Contact

In an emergency, who should we contact?

Name:_____

Relationship:_____

Work Ph:(___)_____Home/Cell Ph:(___)_____

4. Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize West Michigan Family Medicine, PC physicians to treat my child or me. I agree that West Michigan Family Medicine, PC can contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. West Michigan Family Medicine, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

X_____

Signature of patient or parent if minor **Date**

5. Financial Arrangements

Payment for co-pays, deductibles and co-insurance is due at time of service. We accept the following form of payment. Cash, Check, MasterCard, Visa, Discover and Care Credit.

West Michigan Family Medicine, PC

We are a **Patient Centered Medical Home,** focused on you and your relationship with your physician. Our partnership with you means that you will always have an active involvement in your health care plan.

We as your physician and health care team will.

- Provide you with comprehensive, compassionate and effective care.
- Provide you with the opportunity to communicate your concerns about your health and the care you receive.
- Assist in coordinating your care with other qualified physicians and professionals, as needed.
- Respect your privacy. Your medical information will not be shared with anyone unless you give us permission, or it is required by law.
- Provide care that meets your needs and fits with your goals and values.
- Explain your health and illnesses in a way you can understand.
- Provide care that is based on quality and safety.
- Provide same day appointments and 24-hour access to medical care.
- Provide information regarding other resources available to you outside of this office, such as community agencies and services.

We ask that you participate and let us help you.

- Provide us with the information we need to help you obtain your personal goals.
- Do your best to follow a healthy lifestyle and be involved in understanding and managing your health care. Let us know if you are unable to follow the advice of your health care team.
- Tell us about any illnesses, hospitalizations, medication and other health related matters.
- Ask us if you do not fully understand something.
- Notify us of any health care services you received outside of this office. Such as eye exam, foot exam, oral care or an injection you may have received at the pharmacy or urgent care.
- Prepare an Advance Directive and be certain we have it on file.
- Learn about your insurance so you know what is covered.
- Give us feedback so we can improve our services.
- Feel free to talk to us, the more we know about how you feel, the better we can help you.

Establishing a partnership between the patient and the health care team, along with family members and patient advocates, allows decisions to be made that are respectful of the physician's knowledge and experience while making sure the patient's wants, needs and personal preferences are met. The patient is supported by the knowledge that they can make decisions and participate in their own care.

Our office hours are Monday – Friday from 8:30 am – 4:30 pm. Our summer hours, June through August are 8:30 am to 4:00 pm. We are closed for lunch from 12:30 pm-1:30 pm. Our office phone number is 616-785-3883. Our fax number is 616-785-1982. Our after-hour emergency phone number is 616-391-9903. Our billing department phone number is 616-250-5343. Please visit us on line at www.westmichiganfamilymedicine.com to view more information regarding our practice and locations.

WEST MICHIGAN FAMILY MEDICINE, PC
SHELLEY M. DREW, D.O., ASHLEY L. CONNER, M.D.,
JOHN B. MILLETT, M.D.

PATIENT INFORMATION

Our office hours are Monday-Friday 8:30 AM – 5:00 PM
Our phone hours are Monday –Friday 8:30 AM – 4:30 PM September - May
8:30 AM – 4:00 PM June - August
We are closed for lunch from 12:15 PM – 1:30 PM

Payment for services is expected at the time of service. If you have a co-pay, this will be collected when you register. If you are unable to pay your co-pay, you will be asked to reschedule your appointment. It is the patient's responsibility to check with their insurance company about coverage of any test or procedures. We accept cash, check, Visa, Mastercard, Discover and American Express.

A child under the age of 18 will not be seen without a legal guardian. If you absolutely cannot accompany your child to the appointment, you must provide a written consent for us to treat him or her.

Prescription refills will be filled within 48-business hours. We recommend you call the office one week before your prescription expires.

Appointment cancellation: We request a 24- hour notice if you have to change your appointment. **If a 24 hour notice is not given you will be charged $40.00 for an office visit; for an extended visit or procedure you will be charged $60.00.** If you arrive late for your appointment, you may be asked to reschedule.

Form fee. Patients requesting a form to be completed by the physician will be charged a fee. The dollar amount will be decided by the physician.

PLEASE NOTE

Our after-hour call service has increased their rate per patient phone call. For excessive or inappropriate use of this service, the charges will be passed on to the patient.

YOUR HEALTH

Please feel free to talk to us. The more we know about how you feel, the better we can help you.

I acknowledge that I have received and read the patient information form.

_____ _____

Print name Signature

Date _____

WEST MICHIGAN FAMILY MEDICINE. P.C.
1550 3 MILE ROAD NW
WALKER, MI 49544

SHELLEY M. DREW, D.O.
ASHLEY L. CONNER, M.D.
JOHN B. MILLETT, M.D.

I _____ give West Michigan Family
Patients name
Medicine, P.C. my permission to release medical information regarding myself to
_____ my _____
Who is receiving the information Relationship to patient

I understand that I may change my decision at any time by informing you of this in writing.

Signature:_____ Date:_____
Patient

Notice of Privacy Practices

Form 7.20

West Michigan Family Medicine, PC

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

West Michigan Family Medicine, PC 1550 3 Mile Road NW Walker, MI 49544

We will not retaliate against you for filing a complaint.

Effective Date 9/3/2014 Publication Date 9/3/2014

WEST MICHIGAN FAMILY MEDICINE, PC
Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

Name of patient _____ Date of Birth

Signature of patient or personal representative

If signed by personal representative, relationship to patient

Date

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

Refused to Sign ☐ Physically unable to Sign ☐

Other:

Employee Signature: _____

Date: _____

ADULT HEALTH HISTORY

APPROPRIATE FOR 18 YEARS AND OLDER

NAME: _____ BIRTHDATE: _____

☐ MALE ☐ FEMALE

PERSON COMPLETING THIS HISTORY: _____ TODAY'S DATE: _____

HEIGHT _____ PRESENT WEIGHT _____ LBS.

HIGHEST WEIGHT _____ LBS. LOWEST WEIGHT _____ LBS.

MEDICAL HISTORY:

Have you ever had or do you now have any of the problems listed below?

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Depression	☐	☐	Mononucleosis
☐	☐	Anemia (low blood)	☐	☐	Epilepsy	☐	☐	Phlebitis (Blood Clot in Veins)
☐	☐	Other blood disorder	☐	☐	Eye disease	☐	☐	Sexually transmitted disease
☐	☐	Arthritis/Rheumatism	☐	☐	Gall bladder disease	☐	☐	(Gonorrhea, Herpes, Syphilis)
☐	☐	Asthma	☐	☐	Gout	☐	☐	Sickle Cell
☐	☐	Back trouble	☐	☐	Heart trouble	☐	☐	Sinus Problems
☐	☐	Bleeding tendencies	☐	☐	Hepatitis/Jaundice	☐	☐	Stroke
☐	☐	Bronchitis/Pneumonia	☐	☐	Hemorrhoids	☐	☐	Stomach trouble/Ulcers
☐	☐	Emphysema	☐	☐	Hernia	☐	☐	Thyroid problems
☐	☐	Cancer/Tumor	☐	☐	High blood pressure	☐	☐	German measles (Rubella)
☐	☐	Colitis/Bowel problems	☐	☐	Hypoglycemia	☐	☐	Tuberculosis
☐	☐	Convulsions (Seizures)	☐	☐	Kidney/Bladder trouble	☐	☐	Have you ever had a positive TB test?
☐	☐	Diabetes (Sugar)	☐	☐	Migraine headaches			If yes, when? _____
☐		Other: _____						Year of last Tetanus shot: _____

If any "Yes" or "Other" is checked, please explain: _____

_____

List any surgeries/operations/hospitalizations: _____

_____

List any serious accidents: _____

_____

Have you had trouble with:

Yes	No		Yes	No		Yes	No	
☐	☐	Allergies	☐	☐	Chronic cough	☐	☐	Bowel problems (such as:)
☐	☐	Abdominal pain	☐	☐	Coughing up blood	☐	☐	Constipation
☐	☐	Vision	☐	☐	Chest pain	☐	☐	Diarrhea
☐	☐	Hearing	☐	☐	Sleeping	☐	☐	Change in bowel habits
☐	☐	Excessive bleeding	☐	☐	Dizziness/Fainting	☐	☐	Rectal bleeding
☐	☐	Headaches	☐	☐	Fatigue/Tiredness	☐	☐	Heartburn/Indigestion
☐	☐	Shortness of breath	☐	☐	Confusion/Loss of memory	☐	☐	Numbness/Tingling
☐		Other _____						

If any "Yes" or "Other" is checked, please explain: _____

_____

List any allergic reactions or sensitivities to medicine: _____

_____

List any medications you are currently taking: _____

_____

- OVER -

Have you had any of the following illnesses?

☐ Chickenpox ☐ Smallpox ☐ German Measles ☐ Hard Measles
☐ Mumps ☐ Scarlet Fever ☐ Strep Throat ☐ Diphtheria

WOMEN:

Check if you have had problems with:

☐ Breast Lumps
☐ Discharge from Nipples
☐ Vaginal Discharge
☐ Uterine Infection
☐ Menstrual Period
☐ Bleeding between periods
☐ Mother took DES

Age when you had your first period _____
Average number of days of flow _____
Length of time between periods _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Number of living children _____
Do you think you are pregnant now? ☐ Yes ☐ No

Date of last Pap smear _____
Have you ever had an abnormal Pap smear? ☐ Yes ☐ No
Do you regularly perform self breast exams? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No

MEN:

Check if you have had problems with:

☐ Urination ☐ Testicular Pain or Swelling ☐ Prostate Trouble ☐ Impotence

Do you regularly perform testicular exams? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No

FAMILY HISTORY:

Check if any member of your immediate family has had any of the following:

☐ Alcoholism ☐ Anemia ☐ Bleeding Disorder ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Glaucoma
☐ Gout ☐ Heart Disease ☐ High Blood Pressure ☐ Mental Illness ☐ Stroke ☐ Suicide ☐ Tuberculosis

If a parent, brother or sister has died, please list their age(s) _____ and cause(s) of death: _____
_____ _____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No If so, how much? Cigarettes _____ /packs per day _____Cigars per day _____Pip
Do you drink... Liquor? ☐ Yes ☐ No Beer? ☐ Yes ☐ No If so, how much? _____
Do you use illegal drugs? ☐ Yes ☐ No If so, what kind, how much? _____
Have you ever been treated for alcohol or substance abuse? _____ ☐ Yes ☐ No If so, how long ago? _____
Do you drink caffeinated beverages (coffee, cola)? _____ ☐ Yes ☐ No If so, how much? _____
How often do you exercise? _____ What kind? _____
Do you eat a low fat diet? ☐ Yes ☐ No Do you wear seat belts when you are in a car? ☐ Yes ☐ No
Do you wear a helmet when riding a bike or motorcycle? ☐ Yes ☐ No
Do you have smoke detectors in your home? ☐ Yes ☐ No

If any of the following are checked "Yes", please describe: _____

_____

	Yes	No
Are you often dissatisfied with your work?	☐	☐
Are you tense or fearful?	☐	☐
Are you often dissatisfied with your sexual life?	☐	☐
Are you sad or depressed?	☐	☐
Do you ever feel like ending it all?	☐	☐
Do you have any other concerns not previously identified?	☐	☐

_____
Physician Signature Date

*Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____
*Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____

Please place a check mark by the family member with the problem. (Maternal= Mom's side,Paternal= Dad's side)

Name:

	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER
ANEMIA								
ARTHRITIS								
ASTHMA								
BREAST CANCER								
CVA (stroke)								
CANCER								
COLON CANCER								
COPD								
DEEP VEIN THROMBOSIS								
DEPRESSION								
DIABETES								
EYE DISORDER								
GASTRIC ULCER								
HEART DISEASE								
HEMOPHILIA								
HYPERLIPIDEMIA (high cholesterol)								
HYPERTENSION (high blood pressure)								
LIVER DISEASE								
MENTAL ILLNESS								
PULMONARY EMBOLISM								
SEIZURE								
SKIN DISORDER								
SUBSTANCE ABUSE								
THYROID DISORDER								
UROGENITAL DISORDER (kidney/bladder)								
Alcohol Use								
Substance Use								
Tobacco Use								