MMP
MID-MICHIGAN PHYSICIANS, P.C.

**Phone:** (517) 913-3980
**Fax:** (866) 538-6852
*www.lakelansingdoctors.com*

LAKE LANSING
FAMILY PRACTICE

FAMILY MEDICINE &
OSTEOPATHIC
TREATMENT

1568 Lake Lansing Road
Lansing, MI 48912

Arthur J. Ronan, D.O.

Elizabeth Hughes, D.O.

Julie Thomas-Beckett, N.P

# Medical Information Release Form

Name: ______________________________ Date: ____________

I hearby give my permission to release medical information regarding myself to family or friends listed below:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Signature of patient: ______________________________

The following information will assist us in your care, and in any communications with you, while protecting your confidentiality. Please check “Yes” or “No” and fill in the necessary information.

I give my permission to:

| Yes | No | |
|---|---|---|
| ◯ | ◯ | Leave a message with test results on home answering machine? Phone Number: ____________ |
| ◯ | ◯ | Leave a message requesting a return call on home answering machine? Phone Number: ____________ |
| ◯ | ◯ | Leave a message requesting a return call on my work phone? Phone Number: ____________ |
| ◯ | ◯ | FAX test results/information regarding my condition to FAX number? FAX Number: ____________ |
| ◯ | ◯ | May FAX information to and from any provider my physician may refer me to? |

______________________________________________
Signature of patient

MMP
MID-MICHIGAN PHYSICIANS, P.C.

**Phone:** (517) 913-3980
**Fax:** (866) 538-6852
*www.lakelansingdoctors.com*

LAKE LANSING
FAMILY PRACTICE

# Medical History Form



Patient Name: ______________________________ Date: ____________

Date of Birth: ____________________

**CC:** What is the reason for your visit today? ______________________________

______________________________

**HPI:**

**Shaded Area:**
For Office
Use Only

**PMH:** Please list any chronic medical conditions or serious illness you have now or have had in the past.

| Illness: | Date: | Illness: | Date: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please list any surgeries or hospitalizations.

| Reason: | Hospital (or city): | Year: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all medications (including non-prescription, vitamins, calcium, herbal remedies, and birth control pills).

| Name of Medication: | Dosage: | How often: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all medical allergies.

| Name of Medication: | Reaction: |
|---|---|
| | |
| | |

MMP
MID-MICHIGAN PHYSICIANS, P.C.

**Phone:** (517) 913-3980
**Fax:** (866) 538-6852
*www.lakelansingdoctors.com*

LAKE LANSING
FAMILY PRACTICE

# Medical History Form *Continued*



Patient Name: ______________________________ Date: ______________

**FH:** Please fill in health information about your family

| Relation: | Current Age: | Medical Conditions: | If Deceased: Age/Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers | | | |
| | | | |
| | | | |
| | | | |
| Sisters | | | |
| | | | |
| | | | |
| | | | |

Also, please check if your blood relatives had any of the following:

| Disease: | Relationship to you | | Relationship to you |
|---|---|---|---|
| ◯ Asthma or Emphysema | ______ | ◯ Kidney disease | ______ |
| ◯ Cancer | ______ | ◯ Strokes | ______ |
| ◯ High Cholesterol | ______ | ◯ Thyroid disease | ______ |
| ◯ Diabetes | ______ | ◯ Anxiety, depression, or psychiatric problems | ______ |
| ◯ Heart Disease | ______ | ◯ Other | ______ |
| High blood pressure | ______ | | ______ |

## Social History:

What is your marital status? ◯ S ◯ M ◯ D ◯ W

What is/was your occupation? ______________

What is your sexual orientation?
◯ Hetrosexual ◯ Homosexual ◯ Bisexual

Do you drink? ◯ Y ◯ N How much? ______________

Do you follow a special diet? ______________

Do you use tobacco? ◯ Y ◯ N How much? ________ Caffeine? ◯ Y ◯ N

Do you use any street drugs? ◯ Y ◯ N How much? ________

Do you exercise? ◯ Y ◯ N Do you wear a seat belt? ◯ Y ◯ N

Have you had exposure to toxins, chemicals or asbestos? ◯ Y ◯ N

What are the dates of your last vaccination booster?

Tetanus/Diphtheria ________ Polio ________

Measles/ Mumps/Rubella ________

Hepatitus B ________ Influenza ________

Pneumonia ________ Other ________

Do you have a Living Will or Medical Durable Power of Attorney? ◯ Yes ◯ No

If no, would you like information about one? ____
If yes, please bring a copy to your appointment.

If yes, nurse signature: ______________

Date information given: ______________

MMP
MID-MICHIGAN PHYSICIANS, P.C.

**Phone:** (517) 913-3980
**Fax:** (866) 538-6852
*www.lakelansingdoctors.com*

LAKE LANSING
FAMILY PRACTICE

# Review of Symptoms



Patient Name: ______________________ Date: __________

| **Constitutional:** | **Yes** | **No** | **Comments:** |
|---|---|---|---|
| Recent weight change? | ◯ | ◯ | |
| Fatigue? | ◯ | ◯ | |
| Fever? | ◯ | ◯ | |
| Insomnia? | ◯ | ◯ | |

| **Eyes:** | **Yes** | **No** | **Comments:** |
|---|---|---|---|
| Eye exam within the last year? | ◯ | ◯ | |
| Decreased or double vision? | ◯ | ◯ | |
| Eye pain? | ◯ | ◯ | |
| Glasses/contacts? | ◯ | ◯ | |

| **Head, Ears, Nose and Throat:** | **Yes** | **No** | **Comments:** |
|---|---|---|---|
| Headaches? | ◯ | ◯ | |
| Dizziness? | ◯ | ◯ | |
| Ringing in ears? | ◯ | ◯ | |
| Nasal stuffiness? | ◯ | ◯ | |
| Sinus problems? | ◯ | ◯ | |
| Frequent nose bleeds? | ◯ | ◯ | |
| Dental visit within the last year? | ◯ | ◯ | |
| Hoarseness? | ◯ | ◯ | |
| Hearing loss? | ◯ | ◯ | |

| **Respiratory:** | **Yes** | **No** | **Comments:** |
|---|---|---|---|
| Chronic cough? | ◯ | ◯ | |
| Wheezing? | ◯ | ◯ | |
| Shortness of breath? | ◯ | ◯ | |
| Bronchitis/pneumonia? | ◯ | ◯ | |

| **Cardiovascular:** | **Yes** | **No** | **Comments:** |
|---|---|---|---|
| Chest pain? | ◯ | ◯ | |
| Heart racing/skipping? | ◯ | ◯ | |
| H/O heart murmer? | ◯ | ◯ | |
| Swelling in legs/feet? | ◯ | ◯ | |
| High blood pressure/hypertension? | ◯ | ◯ | |

| **Gastrointestinal:** | **Yes** | **No** | **Comments:** |
|---|---|---|---|
| Heartburn? | ◯ | ◯ | |
| Change in frequency or color of stools? | ◯ | ◯ | |
| Trouble swallowing? | ◯ | ◯ | |
| Rectal bleeding? | ◯ | ◯ | |
| Hemoccult within the last year? | ◯ | ◯ | |
| Sigmoidoscopy within the last 5 years? | ◯ | ◯ | |
| Poor appetite? | ◯ | ◯ | |
| Hepatitus/yellow jaundice? | ◯ | ◯ | |

| **Genitourinary:** | **Yes** | **No** | **Comments:** |
|---|---|---|---|
| **Male** | | | |
| Dicharge or sores on penis? | ◯ | ◯ | |
| Testicular pain, mass? | ◯ | ◯ | |
| Sexual difficulties? | ◯ | ◯ | |
| Difficulty urinating? | ◯ | ◯ | |
| Sexually transmitted disease? (STD) | ◯ | ◯ | |

*Please complete other side.*

MMP
MID-MICHIGAN PHYSICIANS, P.C.

**Phone:** (517) 913-3980
**Fax:** (866) 538-6852
*www.lakelansingdoctors.com*

LAKE LANSING
FAMILY PRACTICE

# Review of Symptoms *Continued*



Patient Name: ______________________________ Date: ____________

## Genitourinary:

**Female**

| | Yes | No | If not, when was your last mammogram |
|---|---|---|---|
| Mammogram within the last year? | ○ | ○ | ______ |
| Do you perform self breast exams? | ○ | ○ | ______ |
| Breast lumps or pain? | ○ | ○ | ______ |
| Age at first period? | ______ | | |
| Approximate date of last period/when periods stopped? | ______ | | |
| Approximate date of last pap smear? | ______ | | |
| Any abnormal pap smears? | ○ | ○ | |
| Any vaginal discharge or itching? | ○ | ○ | |
| Sexual difficulties? | ○ | ○ | |
| Sexually transmitted disease? (STD) | ○ | ○ | |
| Urinary problems? | ○ | ○ | |

Number of pregnancies?________miscarriages?________abortions?________

What form of birth control do you use? ______________________________

## Skin:

| | Yes | No | Comments: |
|---|---|---|---|
| Any rashes? | ○ | ○ | ______ |
| Any changes in moles? | ○ | ○ | ______ |
| History of skin cancer? | ○ | ○ | ______ |

## Musculoskeletal:

| | Yes | No | Comments: |
|---|---|---|---|
| Joint pain or stiffness? | ○ | ○ | ______ |
| Back pain? | ○ | ○ | ______ |
| Muscle pain or cramps? | ○ | ○ | ______ |

## Neurologic:

| | Yes | No | Comments: |
|---|---|---|---|
| Fainting? | ○ | ○ | ______ |
| Seizures? | ○ | ○ | ______ |
| Weakness of arms or legs? | ○ | ○ | ______ |
| Tremors? | ○ | ○ | ______ |
| Numbness? | ○ | ○ | ______ |
| Memory problems? | ○ | ○ | ______ |

## Psychiatric:

| | Yes | No | Comments: |
|---|---|---|---|
| Excessive nervousness? | ○ | ○ | ______ |
| Panic attacks? | ○ | ○ | ______ |
| Mood swings? | ○ | ○ | ______ |
| Depression? | ○ | ○ | ______ |

## Endocrine:

| | Yes | No | Comments: |
|---|---|---|---|
| Heat or cold intolerance? | ○ | ○ | ______ |
| Excessive thirst or urination? | ○ | ○ | ______ |
| History of radiation treatment to the head or neck? | ○ | ○ | ______ |

## Hematologic/Lymphatic:

| | Yes | No | Comments: |
|---|---|---|---|
| History of anemia? | ○ | ○ | ______ |
| Easy bruising or bleeding? | ○ | ○ | ______ |
| Chronic swollen glands? | ○ | ○ | ______ |
| Any transfusions? | ○ | ○ | ______ |

## Allergic/Immunologic:

| | Yes | No | Comments: |
|---|---|---|---|
| Known allergies? | ○ | ○ | ______ |

## Acknowledgment of Notice of Privacy Practices

I, ______________________________________________, acknowledge

that I have received a printed copy of the Notice of Privacy Practices for

Mid-Michigan Physicians,P.C.

_______________________________________________ ________________

Patient Signature Date

PHONE: (517) 913-3980
FAX: (866) 538-6852
*www.lakelansingdoctors.com*

# MID-MICHIGAN PHYSICIANS, P.C.
# PATIENT REGISTRATION FORM - 2007

## PERSONAL INFORMATION

NAME: ______________________

ADDRESS: ______________________

CITY: ______________________

STATE: __________ ZIP: __________

HOME PHONE: ______________________

WORK PHONE: ______________________

SSN#: ______________________

EMAIL: ______________________

DRIVERS LIC.#: ______________________

DATE OF BIRTH (DOB): ______________________

SEX: MARITAL STATUS: S / M / D / W

SPOUSE NAME: ______________________

SPOUSE WORK PHONE: ______________________

SPOUSE DOB: ______________________

SPOUSE SS #: ______________________

** (PERSON RESPONSIBLE FOR MINOR UNDER THE AGE OF 18) **

NAME: ______________________

RELATIONSHIP TO PATIENT: ______________________

ADDRESS: ______________________

BIRTHDATE: ______________________

SOC SEC #: ______________________

EMPLOYER: ______________________

## EMPLOYMENT INFORMATION

EMPLOYER: ______________________

ADDRESS: ______________________

______________________

SPOUSE EMPLOYER: ______________________

ADDRESS: ______________________

______________________

## INSURANCE INFORMATION

**PRIMARY** INSURANCE INFORMATION

COMPANY: ______________________

GROUP #: ______________________

POLICY #: __________ SUFFIX # __________

POLICY HOLDER: __________ DOB: __________

**SECONDARY** INSURANCE INFORMATION

COMPANY: ______________________

GROUP #: ______________________

POLICY #: __________ SUFFIX: __________

POLICY HOLDER: __________ DOB: __________

## Emergency Contact

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Relationship To Patient: ______________________

Home Phone: ______________________

Work Phone: ______________________

## Minor Child/Family Representative Consent to Treat Without a Parent/Guardian Present

I (Parent/Guardian Full Name) ______________________ give permission for my minor child,
(Childs Full Name) ______________________ to receive medical treatment from a physician at this office, without a parent or guardian present at the office.

Parent/Guardian Signature: ______________________ Date: __________

Family Representative Name: ______________________ Date: __________

## INSURANCE AUTHORIZATION INFORMATION

MEDICARE PATIENTS: I request payment of authorized Medicare benefits made either to me or on my behalf to Mid-Michigan Physicians, Inc. for any services furnished to me by them. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits for related services.

Signature: ______________________ Date: __________

MANAGED CARE PATIENTS: (PHP, BCN, M-Care, Etc.) I understand that I am personally responsible for getting any authorizations from my primary care physician before services are rendered, and failure to do so will result in my being held responsible for payment in full when services are rendered.

Signature: ______________________ Date: __________

I hereby authorize any treatment and care given and will be financially responsible for non-covered services. I am responsible for knowing what my insurance limitations are.

Signature: ______________________ Date: __________

I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________ Date: __________