Grand Traverse Internal and Family Medicine

Welcome to Grand Traverse Internal and Family Medicine!

Your designated Patient-Centered Medical Home

Phone: (231) 935-0850 Fax: (231) 935-0869

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. gtinternists.com** /forms/New Patient Packet

- Fill out the ***Patient Registration*** and ***Medical History*** forms and bring with you.
- Bring Your insurance cards **(required every visit)**
- Bring your driver's license.
- Bring your current prescription bottles so we can record them correctly.
- Bring your Vaccination history with you.
- Review your insurance coverage to determine your benefits **BEFORE** the appointment.
- Copays and deductibles are due at the time of service.

***Our Location and Hours*:**

- Address: 5015 North Royal Drive Traverse City, MI 49684
- Office Hours: Monday - Friday 8:00 a.m. to 5:00 p.m.
- Lab Hours: Monday - Friday 7:30 a.m. to 4:30 p.m. (closed 12:30 to 1:30 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 **231-935-0850 ext. 0** or request an appointment through your **patient portal** to schedule.
- Please talk to the receptionist to make an appointment.
- Speak with the clinical staff to discuss current health concerns.
- Please call us if you are unable to keep your appointment. We require 24-hour notice.
- If you need to be seen urgently, we will try to schedule you for a same day appointment.
- We reserve the right to charge $75.00 for no show appointments and same day cancelations.

After Hours:

- If you have an **emergency** condition, please call **911.**
- If you have an **urgent** condition, please call 231-935-0850 ext. 5 to reach our on-call physician.

Prescription Refills:

- Please request your prescription refills at your office visits.
- Request through the **patient portal** is 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 231-252-0710 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)* _____

Former/Maiden Name *(If applicable)* _____

Mailing Address _____

Phone Number(s) _____ *(Home)* _____ *(Work)* _____ *(Cell)*

Date of Birth _____ **Social Security Number** _____

Email Address _____ **Sex Assigned at Birth** _____

Marital Status_____ **Gender Identity**_____

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 *Decline to Report

Ethnicity *(Circle One)* *Hispanic *Non-Hispanic *Decline to Report

Other Information

Employer Name _____

Employer Phone Number and Location *(City, State)* _____

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

Emergency Contact Name _____

Phone Number(s) _____ *(Home)* _____ *(Work)* _____ *(Cell)*

Relationship *(Spouse, Parent, Sibling, Child, 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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Medical History Questionnaire

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 _____

Medical History

Please list all the medications you are currently taking.

Name of Medication	Dosage

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

_____

_____

_____

Current Date _____

Patient Name _____

Patient Date of Birth _____

Medical History (continued)

Please tell us about your immunization history*

**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)*

**Please list any other immunizations recently received in the remaining space*

Name of Immunization	**Most Recent Immunization Date** *(Or Never or Refused)*
Pneumococcal (*Pneumovax)*	
Pneumococcal (*Prevnar*)	
Tetanus, Diphtheria, Pertussis (TD/TDAP)	
Influenza	
Measles, Mumps, Rubella (*MMR)*	
Shingles (*Zoster)*	
Hepatitis B	
Meningococcal	
Chicken Pox (*Varicella*)	
HPV	
Others (List below)	

Current Date _____

Patient Name _____

Patient Date of Birth _____

Medical History (continued)

Has a doctor or other health care provider ever told you that you have any of the following?
(Please check all that apply)

□ High Blood Pressure □ High Cholesterol □ Coronary Artery Disease □ Diabetes

□ Diabetes only in Pregnancy □ Colon Cancer or Polyps □ Asthma □ Breast Cancer

□ HIV or AIDS □ Inflammatory Bowel Disease/Crohn's Disease

Are you currently receiving any of the following? *(Please check all that apply)*

□ Radiation Therapy □ Chemotherapy □ Oral Steroid Medications

What is your current pregnancy status?

□ Pregnant □ Not Pregnant □ Chance of Being Pregnant

Date of last menstrual period _____

***Please tell us about any surgeries or hospitalizations you have had**
** Please indicate the type of surgery and/or reason for hospitalization and the approximate date*
** Please include hysterectomies, mastectomies, colonoscopies, and colectomies, if applicable*

Type of Surgery or Reason for Hospitalization	**Approximate Date** *(Year)*

Current Date _____

Patient Name _____

Patient Date of Birth _____

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				

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Current Date _____

Patient Name _____

Patient Date of Birth _____

Social History

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

Are you a: □ Current Smoker □ Former Smoker □ Never a Smoker?

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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Current Date _____

Patient Name _____

Patient Date of Birth _____

Sexual History

Have you had sex in the last 12 months? □ Yes □ No

If yes, with: □ Men Only □ Women Only □ Both Men and Women

If yes, did you use protection? □ Yes □ No

Have you ever had a Sexually Transmitted Disease? **□ Yes** □ No

Chlamydia? □ Yes □ No

Gonorrhea? □ Yes □ No

Syphilis? □ Yes □ No

Herpes? □ Yes □ No

Other? □ Yes □ No

Asthma History

Do you have coughing, wheezing, shortness of breath or tightness in the chest during the day?

□ Never □ Once every 2 weeks □ Once a week

□ Twice a week □ Several days a week □ More than half the days of a week

□ Nearly every day □ Frequently/every day and/or night

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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)			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Please list any specific questions or concerns you have for the provider _____

_____

_____

Would you like information regarding available community resources and assistance programs? If so, please list your interests/needs here _____

_____

Grand Traverse Internal and Family Medicine

Authorization for the Use and Disclosure of Protected Health Information

Please complete the following and send it to your previous physician.

Release Records from:

Name of former Physician or Clinic: _____

Address: _____

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

____*Medical records **(ONLY LAST 2 years seen)**

**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: _____ Continuation of Care _____ Insurance

_____ 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: GTIFM 5015 N. Royal Dr. Traverse City, MI 49684 Phone: 231-935-0850 Fax: 231-935-0869

Dr. Oakley **Dr. Klettner** **Dr. Bultemeier** **Dr. Yates** **Dr. Hughes** **Dr. Schreiber**
Dr. Vollbrecht **Jessica Mastbergen, DNP**

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 Grand Traverse Internal and Family 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 Grand Traverse Internal and Family Medicine, nor will it affect my eligibility for benefits.

_____ _____
Signature *Date*

_____ _____
Name – Print *Date of Birth*

_____ _____
Name of Personal Representative *Relationship to Patient*