Leelanau Family Practice

Care for Life

New Patient Information

Patient Name (First)_____(MI) ___ (Last)_____

(preferred name)_____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ Email _____

How is it best to communicate with you? *Check all that apply.*
__ email __ text messages __ home phone __ cell phone __ can we leave a voice message?

I would like to receive personalized messages from Leelanau Family Practice for? *Check all that apply.*
__ Lab results __ Health Maintenance __ Prescription Sent __ General Notifications (ex. Flu clinic)

Social Security Number # ____-___-_____ Date of Birth ____/____/_____

Birth Sex ___ Male ___ Female
Sexual Orientation __ Heterosexual __ Gay __ Lesbian __ Queer __ Bisexual
__ Other(please state your sexuality)_____
Marital status ___ Single ___ Married ___ Divorced ___ Partner ___ Widowed

Drivers license number _____

Employer _____ Occupation_____

Employers address_____ City _____ State____

Zip code _____ Employers phone _____

Emergency Contact Name_____ Relationship _____
Emergency contact address_____City_____state __ phone _____

Name _____ Date of Birth _____

Medical Insurance Information

Plan Name _____ ID number _____Group #_____

Name of insured _____ Date of Birth of insured _____

Relationship to Insured _____ Policy Number _____ Start Date _____

Medical History

Are you under the care of a physician now? *(name,phone)*_____

Past Medical History

Have you had or do you have any of the following?

__ High blood pressure (hypertension)
__ High cholesterol
__ Diabetes *(type)* ___
__ Asthma
__ COPD - emphysema
__ Anemia
__ Seasonal allergies (hayfever)
__ Headaches
__ Migraines
__ Heartburn (reflux/GERD)
__ Thyroid disease (hypothyroidism/Graves disease)
__ Cancer (type)_____
__ Leukemia (type)_____
__ Kidney disease
__ Liver disease
__ Alcoholic
__ OTHER _____

_____

__ Dementia (memory loss)
__ HIV/AIDS
__ Seizures/ epilepsy
__ Chron's or Ulcerative Colitis
__ Irritable bowel/ chronic diarrhea or constipation
__ AutoImmune disease
__ Arthritis
__ Stoke(s)
__ Heart attack(s)
__ Congestive heart failure
__ Hepatitis *(type)* ____
__ Chronic Pain disorder (fibromyalgia/PMR/etc)
__ Atrial Fibrillation (a fib)
__ Osteoporosis or osteopenia
__ Substance Abuse
__ Congenital disorder _____

Surgical History

Please list all surgeries, procedures or interventions and dates.

DATE PROCEDURE

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Leelanau Family Practice PC, Jessica Paquette DO, Jennifer Littlefield FNP, Molly Lowe FNP
718 N St Joseph St, K1, Suttons Bay, Mi 49682 Phone (231)386-0088 Fax (855)537-4321

Name ____ Date of Birth ______________

Allergies

Please list all allergies and the reaction you had to it.

ALLERGEN REACTION

_______________ ___________________________________

_______________ ___________________________________

_______________ ___________________________________

Medications

Please list all medications you take including supplements

Medication	Dose	Frequency

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Name _____ Date of Birth _____

Substance Use History

Do you use tobacco products? __ Yes __No __ Quit*(date)*_____

If yes, do you smoke? __ Yes __ No

Vape? __ Yes __ No

Chew? __ Yes __ No

Do you drink alcohol? __ Never __ once a month or less __ monthly __ weekly __ daily

When drinking,How much do you drink daily? __1-2 drinks __3-4 drinks __5-6 drinks __often more than 6/day

How often do you have more than 6 drinks in a day? __ never __ occasionally __ often

Have you ever considered cutting down on your drinking? ___ Yes ___ No

Do you use(have used) other substances? ___ No ___ Marijuana ___ Cocaine ___ Meth __ PCP

___ Mushrooms ___ Heroin ___ Opioids(not prescribed to you)

Cancer Screening

Over 45 years old, date of your last colon cancer screen? _____ colonoscopy _____ cologuard ____ other

Female Patients

Date of last Pap smear (over 21 years old)? _____

Date of last Mammogram (over 40 years old)? _____

Male Patients

Date of PSA (over age 40)? _____

Vaccination History (Y=vaccinated, N=not vaccinated, D=had disease)

Y/N/D	Date	Vaccine	Other details
____	_____	DtaP (Diphtheria, tetanus,pertussis)	_____
____	_____	MMR (Measles,Mumps,Rubella)	_____
____	_____	Hepatitis B	_____
____	_____	Yearly influenza (Flu)	_____
____	_____	COVID 19	_____
____	_____	Shingles	_____
____	_____	Pneumonia	_____
____	_____	HPV (human papillomavirus)	_____
____	_____	Meningitis (Meningococcal)	_____
____	_____	Chicken Pox (Varicella)	_____
____	_____	Hepatitis A	_____
____	_____	Other	_____
____	_____	Other	_____

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Name _____ Date of Birth _____

HIPAA Disclosure

I hereby authorize Leelanau Family Practice to use or disclose my protected health information related to my healthcare.

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Thank you for trusting your medical care to Leelanau Family Practice. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 1 business day prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Signature_____date_____

MEDICAL APPOINTMENT CANCELLATION - NO SHOW POLICY

Effective June 1st, 2018, any patient who fails to show, cancel or reschedule an appointment and has not contacted our office within one business day prior will be considered a **No Show**.

Established Patients:

If an established patient has a **No Show** for an appointment; a letter will be sent to reschedule your appointment and will be considered for a $50.00 fee

Any established patient who is a **No Show** for an appointment a second time; a letter will be sent as a warning and to reschedule. The patient **will** be charged a $50.00 fee.

If a third **No Show** should occur; the patient **will** be charged a $50.00 fee and may be dismissed from Leelanau Family Practice.

New patients who fails to show for their initial visit will ***NOT*** be rescheduled.

The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will still remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office.

You may contact Leelanau Family Practice 24 hours a day, 7 days a week at the

numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Messages left are acceptable.

Leelanau Family Practice (231)386-0088

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature_____date_____

Name _____ Date of Birth _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS
Date: _____, 20____

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.
Patient's Name: _____ Date of Birth: _____, 20____ Social Security Number: _____-____-_____
II. AUTHORIZATION. I authorize _____ ("Authorized Party") to use or disclose the following: ☐ - My medical-related information from _____, 20____ to _____, 20____.Hereinafter known as the "Medical Records."
III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:
LEELANAU FAMILY PRACTICE
718 N St Joseph St. Unit K1
Suttons Bay, Mi 49682
231-386-0088 phone
855-537-4321 fax
IV. PURPOSE. The reason for this authorization is: ☐ - General Purpose. At my request (general). ☐ -Transfer of Care. ☐ - Continuation of Care. ☐ - Other: _____.
V. TERMINATION. This authorization will terminate: Upon sending a written revocation to the Authorization Party.
VI. ACKNOWLEDGMENT OF RIGHTS. I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.
Signature of Patient: _____ Date: _____
Print Name: _____ (IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW) The patient is unable to sign due to: (check one) ☐ - Being a Minor. Patient is ____ years old and considered a minor under state law. ☐ - Being Incapacitated. Patient is incapacitated due to: _____.
Signature of Representative: _____ Date: _____
Print Name: _____ Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.