Commerce Internal Medicine, P.C.

PATIENT REGISTRATION FORM

_____
Verified By
(please initial)

_____
Today's Date

DATE_____ ACCOUNT NUMBER _____

DOCTOR _____ MARITAL STATUS S M W D

PATIENT NAME_____ DATE OF BIRTH _____ AGE____

MAIDEN NAME (IF APPLICABLE)_____ PHONE ( )_____

ADDRESS _____CITY _____STATE_____ZIP _____

DRIVER'S LICENSE NUMBER_____ S.S. #_____

YOUR EMPLOYER_____OCCUPATION_____ PHONE ( )_____

CELL PHONE ( )_____

SPOUSE/SIGNIFICANT OTHER
NAME_____THEIR EMPLOYER _____DATE OF BIRTH _____

THEIR OCCUPATION_____ PHONE ( ) _____ S.S. # _____

**PERSON RESPONSIBLE FOR ACCOUNT _____ THEIR PHONE ( ) _____

**PLEASE NOTE: The individual who brings a minor into this office is responsible for payment when services are rendered.

YOUR PHARMACY _____ PHONE ( )_____ CITY _____

RACE _____ LANGUAGE _____ ETHNICITY_____

RELIGION _____ DEPENDENTS_____ REFERRED BY WHOM ____

INSURANCE INFORMATION

BLUE CROSS/BLUE SHIELD

CONTRACT NUMBER_____POLICY HOLDER_____

GROUP NUMBER _____ COVERAGE CODE_____

PRIVATE INSURANCE

INSURANCE NAME_____ POLICY HOLDER _____

GROUP AND/OR POLICY NUMBER _____ S.S.# OF INSURED_____

ADDRESS _____CITY_____ STATE _____ZIP _____

MEDICARE

POLICY NUMBER _____ POICY HOLDER _____

ADDITIONAL INSURANCE_____ POLICY HOLDER _____

EMERGENCY CONTACT (SOMEONE RESIDING OTHER THAN YOUR HOME. IN THIS AREA)

NAME_____ PHONE ( ) _____ RELATIONSHIP_____

ADDRESS _____ CITY_____STATE_____ ZIP _____

I authorize Commerce Internal Medicine, P.C. to release any medical information necessary to process my insurance claims. I authorize payment for medical benefits directly to Commerce Internal Medicine, P.C. For insurance purposes, I permit a copy of this authorization in place of he original.

I understand, I am responsible for any charges incurred that are not covered by my insurance company.

X SIGNATURE _____

PERMISSION TO NOTIFY PATIENTS OF TEST RESULTS

The providers and staff at ***Commerce Internal Medicine, P.C.*** will periodically notify you of your test results from various tests or studies.

Please indicate the phone number (s) below that you would like us to contact you at regarding these results.

1st Contact phone number:_____(cell/home/work)

2nd Contact phone number:_____ (cell/home/work)

___**Yes** CIM may leave a message on my voicemail with my test results.

___**No** CIM may not leave a message on my voicemail with my test results. Instead a message will be left stating your test results are available.

Authorization to release your medical information/results to a family member or representative.

Name: _____ Phone:_____
Relationship:_____

NAME: (PRINT)_____

SIGNATURE:_____ DATE:_____

PATIENT HISTORY FORM

PLEASE ANSWER ALL FO THE FOLLOWING QUESTIONS ON BOTH SIDES OF THIS PAPER

NAME: _____ DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____ TODAY'S DATE: _____

CHIEF COMPLAINT

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

_____

_____

_____

HISTORY OF PRESENT ILLNESS

LOCATION OF THE PROBLEM

OTHER: _____

_____

_____

_____

ON A SCALE OF 1-10, WITH 10 BEING THE MOST SEVERE CIRCLE THE NUMBER THAT BEST DESCRIBES THE PROBLEM.

1 2 3 4 5 6 7 8 9 10

WHEN DID YOU FIRST NOTICE THE PROBLEM?

_____ DAYS AGO _____ WEEKS AGO _____ MONTHS AGO

OTHER _____

HOW LONG DOES THE PROBLEM LAST?

_____ MINUTES _____ HOURS ALWAYS THERE

OTHER: _____

DOES ANYTHING MAKE THE PROBLEM WORSE? Y N

_____

DOES ANYTHING MAKE THE PROBLEM BETTER? Y N

_____

IS ANYTHING OCCURRING AT THE SAME TIME? Y N

IF YES PLEASE EXPLAIN _____

_____

IS THE PROBLEM CONSTANT OR VARIABLE? Y N

IF YES PLEASE EXPLAIN _____

_____

DOES IT INTERFERE WITH YOUR NORMAL DAILY ROUTINE?

Y N IF YES PLEASE EXPLAIN _____

_____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

LIST ANY ILLNESS, HOSPITALIZATION OR SURGERY

	DATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ON ANY MEDICATIONS? (INCLUDING OTC) Y N

NAME DOSE HOW OFTEN?

_____

_____

_____

_____

_____

_____

_____

_____

DO YOU TAKE ASPIRIN OR BLOOD THINNERS? Y N

HAVE YOU EVER BEEN A VICTIM OF: PHYSICAL ABUSE? Y N

NEGLECT? Y N

LIST ALL SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY.

CONDITION			HOW RELATED
BREAST CANCER	Y	N	_____
UTERINE CANCER	Y	N	_____
OVARIAN CANCER	Y	N	_____
COLON CANCER	Y	N	_____
HEART DISEASE	Y	N	_____
PROSTATE CANCER	Y	N	_____

DO YOU SMOKE? YES NEVER QUIT _____

HOW MUCH? _____ HOW LONG? _____

DO YOU DRINK? YES NEVER QUIT _____

HOW MUCH? _____ HOW LONG? _____

DO YOU HAVE ANY ALLERGIES?

CONTRAST DYE OR IODINE? Y N

LATEX? Y N

OTHER? _____

SEXUAL ABUSE? Y N **EMOTIONAL ABUSE?** Y N

Commerce Internal Medicine, P.C.

9640 Commerce Road
Suite 104
Commerce Twp., MI 48382
Phone 248-363-1500

Review of Systems

Do you now or have you had any problems related to the following? Circle Yes or No and please explain any Yes answers in the space provided.

Genitourinary

Retention or urine	Y	N
Pain or burning with urination	Y	N
Urgent urination	Y	N
Frequent urination	Y	N
Loss of urine control	Y	N
Blood in the urine	Y	N
Urinary Tract infection	Y	N
Painful Intercourse	Y	N
Abnormal/Painful Periods	Y	N
Abnormal Vaginal Bleeding	Y	N
Abnormal Vaginal Discharge	Y	N

Other: _____

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other: _____

Skin

Rash	Y	N
Boils	Y	N
Persistent Itching	Y	N

Other: _____

Allergy / Immunology

Hay fever	Y	N
Drug Allergies	Y	N

Other: _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Glaucoma	Y	N

Other: _____

Ear / Nose / Throat / Mouth

Ear infection	Y	N
Sore Throat	Y	N
Sinus problems	Y	N

Other: _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other: _____

Cardiovascular

Chest pain	Y	N
Heart attack	Y	N
Heart murmur	Y	N
Mitral valve prolapse	Y	N
Antibiotics before dentist visit	Y	N
Irregular beat or palpitations	Y	N
High blood pressure	Y	N

Other: _____

Pain Assessment

Location: _____

Severity: 1 2 3 4 5 6 7 8 9 10 (worst)

Gastrointestinal

Abdominal pain	Y	N
Nausea or vomiting	Y	N
Indigestion or heartburn	Y	N

Other: _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other: _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness or Tingling	Y	N

Other: _____

Endocrine

Excessive Thirst	Y	N
Too hot or cold	Y	N
Tired or sluggish	Y	N

Other: _____

Hematology / Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N

Other: _____

Psychological

Are you satisfied with your life?	Y	N
Do you feel depressed?	Y	N
Have you considered suicide?	Y	N

Other: _____

MD/NP Sig. _____ Date: _____

MD/NP Init. _____ Date: _____

MD/NP Init. _____ Date: _____

MD/NP Init. _____ Date: _____

MD/NP Init. _____ Date: _____

MD/NP Init. _____ Date: _____

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Patient's Advance Directive

To my family, my physician, my clergy, my substitute decision-maker in the Durable Power of Attorney:

I, _____, being of sound mind, make this statement as an indication of my choice of medical care and as a directive to be followed if I become unable to participate in decisions regarding my health care. These instructions reflect my commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only to prolong the process of my dying if I should be in an incurable or irreversible physical condition with no reasonable expectation of recovery.

These instructions apply if I am: (a) in a terminal condition; or (b) permanently unconscious; or (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

If I am in any one of the conditions described above, I have indicated my wishes in regard to the following forms of treatment:
(Please check your choices)

Cardiac resuscitation	☐	I do want
	☐	I do not want
Mechanical respiration	☐	I do want
	☐	I do not want
Feeding tubes	☐	I do want
	☐	I do not want
Kidney dialysis	☐	I do want
	☐	I do not want
Chemotherapy	☐	I do want
	☐	I do not want
Antibiotics	☐	I do want
	☐	I do not want
Intravenous fluids	☐	I do want
	☐	I do not want

(For additional instructions, add pages as necessary.)

These directives express my right to refuse treatment and they are instructions to my substitute decision maker as constituted in the Durable Power of Attorney instrument. I intend that my instructions be carried out unless I have rescinded them in a new written declaration or by a clear oral expression that I have changed my mind.

_____

(Signature) (Date)

_____

(Witness) (Date)

Witness

My designated decision maker is _____

whose address and current phone is _____

_____

The standard operating procedures of most health care facilities assume that you would want life-sustaining procedures unless you indicate otherwise.