MichiganHEALTH
SPECIALISTS

New Patient Registration **Date:** _____

Legal Name of Patient		
Last:	First:	Int:
Address Line 1:		
Address Line 2:		
City:	MI	Zip:

Other Patient Information	Marital Status:	
DOB:	Married	Single
Phone (Home):	Divorced	Separated
Phone (Work):	Widowed	
Sex: MALE FEMALE		

Emergency Contact			Patient Place of Employment		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
Relationship:			Position:		

How did you hear about us: _____

_____

I authorize use of this form and the release of information to all my insurance companies. I understand that I am responsible for my bill, and I authorize my provider to act as my billing agent in helping me obtain authorization to be used in place of the original.

_____ _____

Printed Legal Name of Patient Signature of Patient or Legal Representative

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Adult Medical History

Name: _____ **Date:** _____

Please list all medical conditions (Past and Present)

Problem & Duration	Problem & Duration
1	4
2	5
3	6

Please list all medications (including OTC, herbals, prescriptions)

Medication & Dosage	Medication & Dosage
1	4
2	5
3	6

Please list all allergies (Medication, food, latex)

Allergy & Reaction	Allergy & Reaction
1	4
2	5
3	6

Please list all hospitalizations and/or surgeries (inpatient and outpatient)

Procedure/Reason & Date	Procedure/Reason & Date
1	4
2	5
3	6

Please list your most recent:

Women Only	Men Only
Mammogram:	Rectal Exam:
PAP:	PSA:
Period:	Testicular Check:
Both Men & Women	
Tetanus Shot:	Hepatitis Screen:
Influenza Shot:	Pneumonia Shot:
Covid-19 Shot:	Varicella Shot or Chickenpox:

Family History: Please circle any of the following illnesses if they are present in your IMMEDIATE family (Mom, Dad, Siblings, Children, Grandparents)

Illness	Relation	Illness	Relation
Heart Attack / Bypass		Birth Defects	
Breast Cancer		Asthma	
Cancer		Kidney Disease	
Hypertension		Stroke	
Allergies		Sickle Cell Anemia	
High Cholesterol		Diabetes	
Seizures		Arthritis	

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Social History: Please answer the following questions

Who do you live with? _____

Do you live in (circle one): House Apartment Other

What kind of diet do you follow? _____

Do you/ have you smoked cigarettes? _____

How many: _____ How long: _____

Do you use e-cigarettes or Vape? _____
How many: _____ How long: _____

Do you drink alcohol? _____

How Much: _____ How long: _____

Do you use illicit drugs? _____

What type? Please circle all that apply

Marijuana / Crack / Cocaine / Heroin / Other How often? _____

Have you ever had any sexually transmitted diseases (STD's)? Please circle all that apply:

Chlamydia / trichomonas / genital herpes / genital warts / syphilis / gonorrhea

Review of Systems: Mark with an "X" if you are experiencing any of the following:

"X"	Problem	"X"	Problem
General and Hormonal		***Skin***	
	Change in weight		Rashes/itching/lumps/moles
	Fever	***Stomach/Intestines***	
	Fatigue		Difficulty in swallowing
	Not feeling well		Nausea/vomiting
	Increase/decrease in appetite		Constipation
	Trouble sleeping		Abdominal pain
	Snoring		Jaundice (yellowing of eyes)
	Feeling HOT-as compared to others		Hepatitis
	Feeling COLD- as compared to others		Vomiting blood
	Change in skin		Blood in stool
	Skin Problems:		Black, Tarry stool
	Change in hair pattern/amount		Hemorrhoids
	Eating too much		Heartburn
	Drinking too much	***Kidneys/Bladder***	
Eye/Ear/Nose/Throat/Neck			Pain during Urination
	Vision problems		Wake up to urinate
	Red Eye(s)/ Double vision		Frequent urination
	Ear pain/ drainage		Blood in urine
	Ringing in ears		Difficulty starting urine stream
	Runny nose		Leaking urine
	Nose bleeds		Stones
	Sore throat or tongue		(MEN) Testicular mass/pain
	Hoarseness		(MEN) Problems with erection
	Lumps/Swelling in neck		(MEN) Sexual problems
Heart/Lungs/Circulation			(WOMEN) Vaginal discharge/infections
	Chest pain		(WOMEN) Painful periods/heavy periods
	Shortness of breath		(WOMEN) Irregular/missed periods
	- while lying down		(WOMEN) Sexual problems/discomfort
	-in the middle of the night	***Muscles and Joints***	
	-with exercise		Pain or stiffness in joints
	Fainting or lightheadedness		Swelling or redness in joints

	Heart fluttering		Backache
	Turning blue		Weakness or cramps
	leg cramps with exercise	***Brain and Nerves***	
	Wheezing		Headaches
	Cough		Numbness/Tingling
	Edema (Swelling of legs)		Seizures
Emotional/ Mental			Memory problems/confusion
	Anxiety/nervousness		Unsteady when walking or sitting
	Depression		
	Personality change/mood swings		

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Pain Management/Controlled Substance Contract

Michigan Health Specialists (MHS) is committed to working with you in your efforts to get better. To help you in this journey, we agree that:

- We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will notify you in advance.
- We will make sure your treatment is as safe as possible while practicing the best practices recognized within pain management. *Keep in mind, most narcotics are used for short-term treatment.*
- We will keep track of your prescriptions and test for drug use regularly to monitor your wellness and safety.
- We will help connect you with other forms of treatment to help you with your diagnosis as well. If you become addicted to these medications, we will help you get treatment and get off of the medication that is causing the problem safely, without getting sick.

Please remember that many of the medications that we prescribe can often have adverse side effects such as sleepiness, dizziness, respiratory distress, and other symptoms described in detail within your prescription paperwork.

As a patient at MHS, I agree to the following:

- I understand that I have a chronic pain problem that currently requires the prescription of narcotic/pain management and/or other controlled substances to increase my ability to function.
- The risk and use of controlled substances have been discussed with me and I have reviewed the disclaimers and paperwork associated with my medications. I am aware that I should discuss my questions about the prolonged use of my medications and/or side effects with my MHS provider or a pharmacist.
- I understand the goals of the gradual reduction in medication are to improve my ability to work and function, and to help my condition improve as much as possible without causing dangerous side effects.
- I will keep all of my scheduled appointments with my provider and any other team members in and out of the office for my treatment.
- I will participate in all other types of treatment that I am asked to partake in.
- I will make sure that I have an appointment no sooner than one month for my refills. I understand that no controlled substance will be filled over the phone, and no early refills will be authorized.
- I am responsible for my medications. I will not sell, share, or trade my medications. I will not increase my dosage without consulting my provider.
- If my medication is lost or stolen, I understand that it will not be replaced until my next appointment when the refill is due.
- I understand that I am subject to random drug screens, either oral or urine. If I refuse to submit a drug screen, my medications will be withheld.
- I understand that my provider will obtain a MAPS report to monitor the controlled substance prescriptions that I have filled.
- I will not use illicit drugs such as cocaine, heroin, or amphetamines. This can result in my discharge from the practice or my pain management treatment.

Signature: _____ **Print Name:** _____

Notice and Acknowledgement of Patient or Legal Representative

Patient Name: _____ *DOB:* ____/____/_____

Legal Representative (Print): _____

Relationship to Patient: _____

Privacy Practice Policy: I acknowlege that I have recieved the attached notice of privacy practices. I am aware tht Michigan Health Specialists requires my signature to release my protected health information on a separate form and will not release my confidential health information unless under my authorization.

_____

Signature of patient or legal representative Date

Consent to Treatment: I hereby voluntarily request, consent to, and authorize my attending physician, his/her associates, assistants, or other practitioners under his/her orders to attend me and provide my medical treatment and care, including, but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations in this facility.

_____

Signature of patient or legal representative Date

Agreement to Pay for Services: I understand that I am liable and responsible for any health insurance deductables and co-insurance portions of my medical bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as legal representative or as patient. I further understand that my treatment may require more than one occasion of service, therefore, this consent shall carry full force and effect form the date of signature until I am discharged from further outpatient treatment.

_____

Signature of patient or legal representative Date

Advanced Directives: I understand that I have the right to provide this facility with advance directives regarding medical treatment decisions, including the right to refuse unwanted medical treatment or ask that it be withdrawn.

I currently (__)Do Have (__)Do Not Have any such directives formally written

_____

Signature of patient or legal representative Date

_____

Witness for Michigan Health Specialists Date

Personal Preference Authorization Form For Protected Health Information

Patient: _____ gives Michigan Health Specialists permission to:

(Please initial each preference)

____ Call my home or cell phone about appointments

____ Leave messages on my answering machine or voicemail regarding appointments

____ Call my place of work if necessary ( ) _____-_____

____ Leave messages on my email at _____

____ Leave messages regarding appointments and/or medical coditions with the person(s) printed below:

Name: _____ Relationship: _____

Name: _____ Relationsip: _____

Name: _____ Relationship: _____

____ May release a copy of my medical records to:

(I understand that there may be a fee involved)

Name: _____ Relationship: _____

Please note: Results WILL NOT be released over the phone to a patient or representative at any time or for any reason.

This authorization will be in effect unless revoked in writing by patient or legal representative.

_____

Signature of patient or legal representative Date

_____

Witness of Michigan Health Specialists Date

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Social Needs Screening

Name:_____
Date:_____
Date of Birth:_____

Do you ever eat less food than you feel you should because there is not enough food? **Yes No**

Do you think completing more education would be helpful to you? **Yes No**

Do you have a hard time finding work or another steady source of income? **Yes No**

Does caring for children, family or friends make it hard for you to take care of your own needs? **Yes No**

In the past, did poor physical or mental health keep you from doing your usual activities? **Yes No**

In the past 12 months, was there a time when you needed to see a doctor but could not because it cost too much? **Yes No**

Are you worried that in the next few months, you may not have safe housing? **Yes No**

Do you ever feel unsafe in your home or neighborhood? **Yes No**

Do you ever have trouble getting to work, school, the store, and/or appointments because you don't have a way to get there? **Yes No**

In the past year, have you had a hard time paying your utility bills? **Yes No**

Would you like to receive assistance for these needs? **Yes No**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT: _____ BIRTHDATE: _____
ADDRESS: _____ SSN: _____
_____ PHONE: _____

RELEASE TO: MICHIGAN HEALTH SPECIALISTS
2065 S. Center Rd.
Burton, MI 48519
PHONE: (810) 235-2004 FAX: (810) 742-2566

RELEASE FROM: _____
_____
_____
PHONE: _____ FAX: _____

SPECIFIC INFORMATION TO BE DISCLOSED:

✓ ANY AND ALL RECORDS *** (see below)
____DIAGNOSTIC REPORTS ONLY
____LABORATORY RESULTS ONLY
____IMMUNIZATIONS
____CHART NOTES (H&P) ONLY
____CONSULTATIONS (SPECIALISTS REPORTS) ONLY
____OTHER _____
____SPECIFIC TIME PERIOD_____

PURPOSE AND NEED FOR DISCLOSURE:

✓ TRANSFER OF CARE - NEW PRIMARY CARE DOCTOR
✓ COORDINATION OF CARE WITH SPECIALIST
____ATTORNEY REQUEST
____SCHOOL/WORK DOCUMENTATION
____SOCIAL SECURITY OR DISABILITY
____WORKMAN'S COMP
____INSURANCE DOCUMENTATION
____OTHER_____

***"ANY AND ALL RECORDS" INCLUDES COMMUNICABLE DISEASE AND INFECTION INFORMATION AS DEFINED BY STATUTE AND MICHIGAN DEPT. OF PUBLIC HEALTH RULES (WHICH INCLUDE VD, TB, HEPATITIS B, HIV, AIDS, AND ARC); ALCOHOL AND DRUG ABUSE TREATMENT INFORMATION PROTECTED UNDER REGULATIONS IN 42 CODE OF FEDERAL REGULATIONS, PART 2; AND MENTAL HEALTH TREATMENT RECORDS, PSYCHOLOGICAL SERVICES AND SOCIAL SERVICES INFORMATION, INCLUDING COMMUNICATIONS MADE BY PATIENT TO A SOCIAL WORKER OR PSYCHOLOGIST.

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing at any time by sending written notification to the Privacy Officer. I understand that revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understand the Practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information I understand I will be notified of the same.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Without expressed written revocation, this consent expires after one year.

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME

_____ _____
DATE RELATIONSHIP TO PATIENT