NORTHERN PINES
HEALTH CENTER, PC

NEW PATIENT REQUEST

We are not accepting any patients requiring chronic pain management or psychiatric services. We do not prescribe narcotics.

DATE: _____ Provider Requested (if preference): _____

How did you hear about us?: _____

Patient Last Name: _____ Patient First Name: _____ Date of Birth: _____

Have you ever been discharged from a medical practice? ☐ Yes ☐ No

If yes, what is the name of the practice you were discharged from? _____

Why were you discharged? _____

Are you currently taking a controlled substance (Ultram, Norco, Percocet, Vicodin, Ritalin, Adderall, Vyvanse or Benzodiazepines such as Xanax, Klonopin, Ativan, Valium, etc.)? ☐ Yes ☐ No

If yes, what is the name of the controlled substance? _____

Have you ever been treated for, or have you ever been diagnosed with chronic pain requiring regularly scheduled controlled substances (Ultram, Norco, Percocet, Vicodin, etc.)? ☐ Yes ☐ No

Do you use any street drugs, such as heroin, methamphetamines, cocaine, or marijuana? ☐ Yes ☐ No

Do you have a medical marijuana card? ☐ Yes ☐ No

Do you plan to obtain a medical marijuana card? ☐ Yes ☐ No

Have you ever been treated for, or have you ever been diagnosed with a psychological disorder, such as psychosis, schizophrenia, or personality disorders? ☐ Yes ☐ No

I certify that the information I have provided is accurate and complete. I understand that my New Patient Request will not be accepted until all information in the registration packet is completed.

X_____ _____

Signature of Patient or Legal Representative Date

Please Mail, fax, or drop off your completed forms:

Mailing/Drop off address:
Northern Pines Health Center
11293 N M-37 Suite A
Buckley, MI 49620

Fax:
(231) 269-4461

FOR OFFICE USE ONLY

Initial: _____ **Date:** _____ **Previous?** Y N **DC?** Y N **Reason:**

Appointment: YES NO

Provider Remarks:

NORTHERN PINES
HEALTH CENTER, PC

11293 N M-37, Suite A - Buckley, MI 49620
Phone (231) 269-4185 - Fax (231) 269-4461

Patient Information

Patient Information	
Patient Name: Date:	
Mailing Address:	
City: State: Zip Code:	
Home Phone:	Cell Phone:
Date of Birth:	Social Security Number:
Email Address:	
Have you ever used any other names since birth? If so, please list:	
Birth Sex: Male Female Decline to Specify	Preferred Pronoun:
Gender Identity: ☐ Identifies as Male ☐ Identifies as Female ☐ Female-to-male (FTM)/Transgender Male/Trans Man ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively Male nor Female ☐ Non-Binary ☐ Chooses Not to disclose ☐ Additional Gender, Specify: _____	
Sexual Orientation: ☐ Lesbian, gay or homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Do not know ☐ Choose not to disclose ☐ Something else, Please describe: _____	
Marital Status:	Primary Language: Translator? Y/N
Race: American Indian Asian Native Hawaiian Black or African American Hispanic White Other Race:_____ Other Pacific Islander Decline to Report	
Ethnicity: Hispanic or Latino Non-Hispanic or Latino Decline to Report	
Employment Status: Full-Time Part-Time Self-Employed Retired Other:_____	
Emergency Contact: Phone:	
Responsible Party(Guarantor) Name: DOB:	
Guarantor Address:	
Guarantor Phone: Relation to Patient:	

Patient Name:_____ Date: _____

Insurance Information	
Primary Insurance:	
Subscriber Name:	Subscriber ID:
Subscriber Date of Birth:	Group Number:
Secondary Insurance:	
Subscriber Name:	Subscriber ID:
Subscriber Date of Birth:	Group Number:

Medical History

List all Providers you are presently seeing:

Current Physicians/Providers	*Specialty*	*Date of Last Appointment (if known)*

List all Medications you are presently taking (include prescription AND over the counter medications):

Name of Medication & Dosage	*Name of Medication & Dosage*

☐ **I do not take any medications**

- If you do not disclose all medications on this form, you may not be accepted as a new patient.

List any allergies/sensitivities and reactions:

_____ _____

_____ _____

Has a doctor or other health care provider ever told you that you have any of the following?

☐ High Blood Pressure	☐ High Cholesterol
☐ Diabetes	☐ Cancer: _____
☐ Coronary Artery Disease (Heart Disease)	☐ Neurological Disorder
☐ Inflammatory bowel Disease/Crohn's Disease	☐ HIV or AIDS
☐ Asthma	☐ Psychiatric Disorder
☐ ADD/ADHD	☐ Addiction
☐ Other: _____	☐ Other: _____

Patient Name:_____ Date: _____

Medical History

List any previous Vaccinations and Approximate Date:

Vaccine		*Approximate Date*
Influenza	☐ Yes ☐ No	
Pneumonia/Prevnar13	☐ Yes ☐ No	
Tetanus	☐ Yes ☐ No	
Varicella (chicken pox)	☐ Yes ☐ No	
Gardasil (HPV)	☐ Yes ☐ No	
Zostavax (Shingles)	☐ Yes ☐ No	
COVID19	☐ Yes ☐ No	
Other: _____	☐ Yes ☐ No	

List any surgeries and the year:

Surgery	*Year*

List diagnosis for any hospitalizations in the past 10 years and the year hospitalized:

Diagnosis	*Year*
☐ **I have no medical Diagnoses**	

Have you had any of the following screening tests?

Test Completed	**Date or Year completed**	**Result (abnormal or normal?)**
☐ PAP Exam ☐ PAP exam and HPV Test		
☐ Mammogram		
☐ Bone Density Test		
☐ Colonoscopy		
☐ Psychological Testing		
☐ Allergy Testing		
☐ PSA (blood test to check prostate gland)		

Patient Name:_____ Date: _____

Medical History

Have you ever had a blood transfusion? ☐ Yes ☐ No

What is your religious preference? _____

Is there anything in your religious belief that affects your medical treatment preferences?

☐Yes ☐ No If so, please explain: _____

Females ONLY:

Pregnancy status: ☐ Pregnant ☐ Not Pregnant ☐ Chance of being pregnant

Start date of last menstrual cycle? _____

How many pregnancies have you had? _____ How many live births have you had? _____

Did you have any pregnancy complications? ☐ Yes ☐ No If so, please specify: _____

Family History

Family Member	*Status*	*DOB or Age*	*Conditions*
Father			
Mother			
Son(s)			
Daughter(s)			
Brother(s)			
Sister(s)			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Patient Name:_____ Date: _____

Social History

Are you…?

- ☐ Current Smoker, Vaper or chewing tobacco user
  - ☐ Every Day ☐ Some Days but not every day
  - How much do you smoke, vape or chew per day? _____
  - Are you interested in quitting? ☐ Ready to quit ☐ Thinking about it ☐ Not ready
- ☐ Former Smoker, Vaper, or tobacco user- When did you quit?

  _____
- ☐ Never Smoker, Vaper, or tobacco user

Are you exposed to secondhand smoke? ☐ Yes ☐ No

If so, where and for how long? _____

Do you use recreational drugs? ☐ Yes ☐ No If so, please specify: _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week do you consume? _____

Do you drink caffeine? ☐ Yes ☐ No How much caffeine per day? _____

☐ Coffee ☐ Soda ☐ Tea ☐ Energy Drinks ☐ Other _____

Have you ever been exposed to toxic exposure such as asbestos, coal mines, radioactive treatments, mold, etc?

☐ Yes ☐ No If so, please specify: _____

Sexual History

Have you had sex in the last 12 months (vaginal, oral, or anal)? ☐ Yes ☐ No

With: ☐ Men Only ☐ Women Only ☐ Both Men and Women

Did you use protection? ☐ Yes ☐ No

Have you ever had a Sexually Transmitted Disease? ☐ Yes ☐ No

If yes, check all that apply:

☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ Gonorrhea ☐ Other: _____

Patient Name:_____ Date: _____

Emotional Health History

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 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 overeating	☐	☐	☐	☐
Feeling bad about yourself, 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 being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts you would be better off dead, or that you want to hurt yourself in some way	☐	☐	☐	☐

Patient Name:_____ Date: _____

New Child Patient Information (Only complete for patients under 18)

Child's Birth History	
Birth Weight:	Birth Height:
Birth Head Circumference:	
Type of Delivery: ☐ Vaginal ☐ C-Section ☐ Breech	
Location of Birth: ☐ Hospital ☐ Home ☐ Other_____	
Complications: ☐ Fetal Stress ☐ Low Birth Weight ☐ NICU ☐ Other_____	
Mother's health during pregnancy: ☐ Normal ☐ Drug/Alcohol Abuse ☐ Gestational Diabetes ☐ Other _____	

Have you ever had the following childhood illnesses?	
Chicken Pox	☐ Yes ☐ No
Mumps	☐ Yes ☐ No
Measles	☐ Yes ☐ No
Rubella	☐ Yes ☐ No
Other	

Do you live at home with both biological parents? ☐ Yes ☐ No

Do you live at home with a biological parent and stepparent? ☐ Yes ☐ No

Do you live at home with a single parent? ☐ Yes ☐ No

Do any other people live in your home besides parents and siblings? ☐ Yes ☐ No

Please explain if other living arrangements: _____

Who is your primary caretaker? _____

If you have any other childcare arrangements, please describe: _____

Do you attend public, private or home school? _____

Do you have any problems in school such as trouble listening, difficulty seeing the whiteboard, poor grades, missing school, performance stress? List any problems, if any: _____

FEMALES ONLY:

Has your menses started? ☐ Yes ☐ No If so, what year? _____

Have you ever had a PAP exam? ☐ Yes ☐ No

How many pregnancies have you had? _____ How many live births have you had? _____

Did you have any pregnancy complications? ☐ Yes ☐ No ☐ N/A

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Consent Agreements

(Please initial each section and sign form)

Acknowledgement of Requirement for Care Management Participation

_____(initials) New patients with uncontrolled chronic or complex health concerns are required to participate in our care management program. Our care management program is based on a team approach between you, your provider, and a care manager/coordinator in our office to provide & coordinate an individual plan to meet specified health goals. **There may be an out-of-pocket cost for these services, depending on your individual insurance plans. Please contact your insurance company to determine any cost responsibilities. If you have questions regarding the Care Management program, please contact our Care Management department at (231) 269-4185 prior to submitting this form.**

Communication Consent Agreement

_____(initials) I do specifically consent to receive telephone calls, short messages ("SMS") text messages or other messages made or delivered to the telephone number(s) I provide verbally and/or in writing to Northern Pines Health Center. I acknowledge that these calls may be made or delivered using an automatic dialing system and/or an artificial or pre-recorded voice made by Northern Pines Health Center or its business associates for purposes of treatment, payment, and healthcare operations.

Authorization to Access Patient Information

_____(initials) As part of our new patient screening process, we ask your permission to access your electronic medical record known as Powerchart. Northern Pines Health Center strives to ensure every patient receives appropriate, quality care. In an effort to ensure this, we use the information obtained from Powerchart to help determine whether our practice is a good fit for you. Northern Pines Health Center is HIPAA compliant, and your medical information will be help in strict confidentiality.

I hereby authorize Northern Pines Health Center to access my electronic medical record, called Powerchart, to complete their assessment. I understand that the electronic medical record (EMR) is comprehensive and includes hospitalizations, medical and psychological diagnosis, labs, diagnostic tests, and procedures. I also hereby authorize Northern Pines Health Center to access my MAPS reports to verify any controlled substance prescriptions.

Medication History Consent

_____(initials) By signing this consent form, you are agreeing that your provider at Northern Pines Health Center may request and use your prescriptions medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing.

Patient or Legal Representative Name (Printed): _____ Date: _____

Patient or Legal Representative Signature: _____ Relationship:_____