Commerce Primary Care

Patient Information Sheet

Patient Name: _____

DOB: _____ **Gender:** Male Female **Marital Status** Single Divorced Married

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Chaldean ☐ Other

Full Address: _____

Primary Phone #: _____ **Alternate Phone #:** _____ **Work Phone #:** _____

Preferred Pharmacy: (Name, City & Street) _____

Emergency Contact: _____ **Emergency Contact Phone #:** _____

Please indicate if there is a family member or friend to whom we are allowed to release or discuss medical information with. I would like to authorize the following person (s) to have access to my medical information:

_____

Primary Insurance:	**Secondary Insurance:**
Company Name:	Company Name:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder:	Policy Holder:
Policy Holder DOB:	Policy Holder DOB:

Preferred Method of Communication:

PLEASE FILL OUT ALL OF THE INFORMATION BELOW & MARK THE BOX WHICH METHOD YOU PREFER*

- ○ **Phone Only** Preferred Phone #: _____ Can we leave a voicemail with medical info: **YES** **NO**
- ○ **Mail Only** Mailing Address: _____
- ○ **Text Message** Preferred Phone #: _____
- ○ **Portal (Web)** **Speak to front office staff about getting the portal invite sent to your email**
- ○ **Email** E-Mail Address: _____

(Note: cannot email protected health information)

I AUTHORIZE COMMERCE PRIMARY CARE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO COMMERCE PRIMARY CARE FOR SERVICES RENDERED. I AGREE TO PAY MY COPAYS, DEDUCTIBLES AND ANY BALANCE THAT IS DENIED OR DISPUTED BY MY INSURANCE COMPANY.

SIGNATURE: _____ **DATE:** _____

Patient Name: _____ Date of Birth: _____

Past Surgical History: Please circle "Y" or "N" for any surgeries you have had in the past

Appendectomy	Y	N	Fracture Repair	Y	N	Pacemaker Implant	Y	N
Breast Biopsy	Y	N	Gallbladder Removal	Y	N	Prostate Biopsy	Y	N
Cardiac Catheterization	Y	N	Hemorrhoid Repair	Y	N	Spleen Removal	Y	N
Cardiac Stent	Y	N	Hernia Repair	Y	N	Thyroid Removal	Y	N
Cataract Surgery	Y	N	Hysterectomy	Y	N	Tonsil Removal	Y	N
Coronary Artery Bypass	Y	N	Knee Surgery	Y	N	Valve Replacement	Y	N
C-Section	Y	N	Mastectomy	Y	N	Vasectomy	Y	N
Dilation & Curretage (D&C)	Y	N	Melanoma removal	Y	N	Wisdom	Y	N

Please list any other surgeries you have had in the past:

_____

_____

_____

Medications: Please list any medications you are currently taking (prescription, vitamin, herbal etc.)

Name	Dose	Schedule
1.		
2.		
3.		
4.		
5.		

Name	Dose	Schedule
6.		
7.		
8.		
9.		
10.		

Please list all allergies you may have:

_____

_____

Social History:

Do you use tobacco? ___ Yes ___ No ___ formerly (year quit_____)

- If yes, how much? _____per day For how long _____

Do you drink alcohol ___ Yes ___ No

- If yes, how often? ___ socially ___ moderately ___ heavy

Patient Name: _____ Date of Birth: _____

Past Medical History: Please circle "Y" or "N" for the following medical conditions/history that pertains to **YOU**:

Anemia	Y	N	Fibromyalgia	Y	N	Liver Disease	Y	N
Arthritis	Y	N	Hearing Problems	Y	N	Migraine/Headache	Y	N
Asthma	Y	N	Heart Attack	Y	N	Osteoporosis	Y	N
Bladder Disorder	Y	N	Heart Disease	Y	N	Pneumonia	Y	N
Cancer-Type:	Y	N	Heartburn/GERD	Y	N	Prostate Disorder	Y	N
COPD	Y	N	Hepatitis	Y	N	Seizures	Y	N
Coronary Artery Disease	Y	N	Hernia	Y	N	Stroke	Y	N
Depression/Anxiety	Y	N	High Cholesterol	Y	N	Thyroid Disorder	Y	N
Diabetes: Type 1 or Type 2	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N
Epilepsy	Y	N	HIV/AIDS	Y	N	Ulcers	Y	N

Please list any other medical history not listed above:

_____

_____

_____

Past Medical History: Please circle "Y" or "N" for the following medical conditions/history that pertains to **YOUR FAMILY**:

Anemia	Y	N	Fibromyalgia	Y	N	Liver Disease	Y	N
Arthritis	Y	N	Hearing Problems	Y	N	Migraine/Headache	Y	N
Asthma	Y	N	Heart Attack	Y	N	Osteoporosis	Y	N
Bladder Disorder	Y	N	Heart Disease	Y	N	Pneumonia	Y	N
Cancer-Type:	Y	N	Heartburn/GERD	Y	N	Prostate Disorder	Y	N
COPD	Y	N	Hepatitis	Y	N	Seizures	Y	N
Coronary Artery Disease	Y	N	Hernia	Y	N	Stroke	Y	N
Depression/Anxiety	Y	N	High Cholesterol	Y	N	Thyroid Disorder	Y	N
Diabetes: Type 1 or Type 2	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N
Epilepsy	Y	N	HIV/AIDS	Y	N	Ulcers	Y	N

Please list any other medical history not listed above:

_____

_____

_____

COMMERCE PRIMARY CARE **248.363.7500**
8800 Commerce Road **248.363.7700 fax**
COMMERCE, MI 48382

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Commerce Primary Care to obtain and/or disclose any health information with other physicians/facilities that I may be referred to, as well as physicians/facilities I have been to in the past.

Patient's Name: _____D.O.B._____

Your previous doctor's name and phone or fax number:

_____

Specific description of information to be released:

LAST 3 YEARS OF: **LABS, CONSULTATIONS, & DIAGNOSTICS (XRAYS, ETC.)**

Purpose of the use or disclosure: continuity of medical care.

The Patient or Patient's Representative must read and initial the following statements:

I understand that:

A. My health care and the payment for my health care will not be affected if I do not sign this form
B. I may see and/or have a copy of the information described on this form and the form itself after I sign it.
C. I may revoke this authorization at any time by notifying the providing organization in writing. However, it has no effect on any actions they took before they received the revocation.

_____ _____
***Signature* of Patient or Patient's Representative** Date:

_____ _____
Printed Name of Patient or Patient's Representative Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
HOWEVER, THIS WILL DELAY OUR EFFORTS TO RETREIVE RESULTS, ETC.

H.I.P.A.A. (Health Insurance Portability & Accountability Act)

ALL PATIENTS

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize **Commerce Primary Care** to release any medical information to any third party payer, or its representative, which may be responsible for payment in my case. As required by law, such information from my medical record is necessary in order to receive reimbursement for any billings rendered relating to my treatment. This includes alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and information about communicable disease and infection as defined by The Department of Public Health rules (Michigan Public Health Code 1988 Public Act 488) which include venereal disease, tuberculosis, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

Initials: _____

I acknowledge that I have read a copy of this office's *Notice of Privacy Practices Form* that is displayed and may receive a copy if requested.

Initials: _____

I understand that I am financially responsible to pay deductibles, co-pays or any other balance that may not be paid by my insurance.

Initials: _____

MEDICARE PATIENT'S ONLY

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and Medigap benefits be made either to me or on my behalf to this provider for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents or Medigap insurer any information needed to determine these benefits or the benefits payable to related services.

***Signature*:** _____

(Patient or Patient's Representative)