GRAND HEALTH PARTNERS
TRANSFORMATIONS HAPPEN DAILY

Patient Information

Legal Name: _____
First Middle Last

Home Address: _____
Street City State Zip

Gender: (circle one) Male Female

Date of Birth: _____ **Social Security #:** _____-_____-_____
mm / dd / yyyy

Email: _____@_____._____ **Used for our patient portal/Billing Dept.*

Marital Status: (Circle one) Single Married Divorced Widowed

Primary Phone: _____ Home / Cell / Work (circle one)
OK to leave a detailed message? Yes / No (circle one)

Secondary Phone: _____ Home / Cell / Work (circle one)
OK to leave a detailed message? Yes / No (circle one)

Ethnicity: (Circle one) Non-Hispanic Hispanic African American Caucasian

Primary Language: _____

If a *GHP patient* referred you to us, please write their name: _____

Emergency Contacts

Emergency Contact 1: _____ _____ _____
Name Relationship Phone #

Emergency Contact 2: _____ _____ _____
Name Relationship Phone #

May we discuss private medical information with Emergency Contact 1 (HIPAA)? (Circle one) Yes / No

May we discuss private medical information with Emergency Contact 2 (HIPAA)? (Circle one) Yes / No

Primary Insurance Information

Name of Primary Insurance: _____ **Member ID/Contract Number:** _____

Policy Holder's Full Name: _____ **Group ID:** _____

Policy Holder's Date of Birth: _____ **Specialist Copay:** _____

Relationship to Policy Holder _____

Secondary Insurance Information

Name of Secondary Insurance: _____ **Member ID/Contract Number:** _____

Policy Holder's Full Name: _____ **Group ID:** _____

Policy Holder's Date of Birth: _____ **Specialist Copay:** _____

Relationship to Policy Holder: _____

2060 East Paris Avenue SE, Suite 100 Grand Rapids, MI 49546
Phone: 616-956-6100 | Fax: 616-956-6637 |Toll Free: 888-691-0050
www.grandhealthpartners.com

Physicians will not be obligated to provide clinical services for any patient who is uncooperative or who does not qualify for the clinical services for valid medical reasons, and such patients may be discharged.

HIPAA COMPLIANCE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, as part of my healthcare, Grand Health Partners (GHP) originates, obtains, and maintains health information and medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment or care. I was able to review Grand Health Partners *Notice of Privacy Practices* that provides a more complete description of how GHP uses and discloses my health information. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this and that I can ask for a copy of the *notice* to take with me. I understand that GHP reserves the right to change the *notice*, and prior to implementation, will post a copy of any revised *notice* in its waiting rooms and will provide me with a copy upon my request. I understand that I have the right to request restrictions as to how my health information is used, and or disclosed, to carry out treatment, payment, or healthcare options. I understand that GHP is not required to agree to the restrictions requested. GHP will consider my request, but I am aware that they are not legally required to accept it and will, given the complexity of multiple methods of dealing with information, most likely elect not to treat me or to disregard it in an emergency situation.

SIGNATURE BELOW INDICATES ACCURACY OF PATIENT INFORMATION, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, AND ACCEPTANCE OF THE FOLLOWING:

- Authorization for providers of Grand Health Partners to examine me and render medical treatment deemed necessary for evaluations, management and treatment of my medical conditions; and to share any information with my primary care physician, any physician to which a referral is made or any other provider of health care products or services.
- I understand that Grand Health Partners may collaborate with other health care providers to coordinate, manage, and provide health care to me and consent to GHP sharing my health information and records electronically for the purpose of treatment, payment or operations, including improving the overall quality of health care services provided to me (example: avoiding unnecessary or duplicate testing, etc.)
- Authorization for Grand Health Partners providers to release to my insurance carrier or benefit plan and its agents any information needed to determine these benefits payable for related services.
- Authorization for direct payment of benefits to Grand Health Partners for services rendered by its providers. I understand I am financially responsible for any balance not covered by my insurance company/benefit plan.
- Authorization for Grand Health Partners to obtain pharmaceutical records from my pharmacy.

Printed Name: _____
First **Middle** **Last**

Patient Signature: _____ Date: _____

Legal Representative (If applicable): _____ Relationship: _____

Legal Representative Signature (If applicable): _____ Date: _____

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PATIENT LAST NAME: _____

History & Physical Information

Physicians + Pharmacy

Full Name of Primary Care Physician: _____

Did this physician refer you to us? Yes / No (Circle one)

PCP Address: _____
Street City State Zip

Physician Phone #: _____ **Physician Fax #:** _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____ **Fax #:** _____

Pharmacy Address: _____
City State Zip

Other Physician(s) (i.e., Cardiologist, GI, etc.)

Please use back of paper if you need more space

Provider Name: _____ **Office Phone #:** _____

Provider Name: _____ **Office Phone #:** _____

Provider Name: _____ **Office Phone #:** _____

Provider Name: _____ **Office Phone #:** _____

Past + Current Medical Diagnosis

***Check all that apply**

- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Depression
- ☐ Diabetes Mellitus Type 2
- ☐ Arrhythmia
- ☐ Lung Disease
- ☐ Seizures
- ☐ Polycystic Ovarian Disease
- ☐ Diabetes Mellitus Type 1
- ☐ Congestive Heart Failure
- ☐ Liver Disease
- ☐ Blood Clots
- ☐ Stroke
- ☐ Anxiety
- ☐ Reflux Disease/GERD
- ☐ Obstructive Sleep Apnea
- ☐ Bleeding Tendencies
- ☐ Peptic Ulcer Disease
- ☐ Hypothyroidism

Other: _____

Other: _____

Other: _____

Prior Surgeries

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

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Prior Surgeries [Continued]

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Any past problems with Anesthesia? Please describe in detail: _____

_____

If necessary, will you accept a blood transfusion? (Circle one) Yes / No

Medications

List all current prescriptions

		Frequency
1. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
2. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
3. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
4. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
5. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
6. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
7. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
8. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
9. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
10. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**

Please list any dietary supplements, herbs, or vitamins you are currently taking:

1. _____ **2.** _____

3. _____ **4.** _____

Medication Allergies	Food Allergies
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Family Medical History

Describe Family Medical Diagnosis

Medical Problem (s):

Father: Alive / Deceased (Circle one)

Medical Problem (s):

Mother: Alive / Deceased (Circle one)

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PATIENT LAST NAME: _____

Family Medical History [continued]

# of Brothers: _____	Medical Problem (s):
# of Sisters: _____	Medical Problem (s):
# of Children: _____	Medical Problem (s):

Social History

Are you currently employed?: Yes / No (Circle one)

Current Employer:_____ **Position:** _____

Are you currently disabled?: Yes / No (Circle one)

If yes, please explain: _____

Caffeine Consumption (Per day)**:** **Regular Pop/Soda: Quantity**_____ **Diet Pop/Soda: Quantity**_____

Coffee: Quantity_____ **Tea: Quantity**_____

Alcohol Consumption (# of drinks per week)**:** ☐ None ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ >20

Smoking: ☐ Never ☐ Former ☐ Current **How often** _____

Chewing Tobacco: ☐ Never ☐ Current

Nicotine: ☐ Patches ☐ Gum ☐ Vaporizer / E-cigarette

Drug Use: ☐ Never ☐ Current ☐ Past

If current, what type: _____ **Medical Marijuana Card?** (Circle one) Yes / No

Previous Medical Testing

Have you had any recent labs done? (Circle one) Yes / No **If yes: Date:** _____ **Location:** _____

Sleep Study **Date:** _____ **Doctor/Location:** _____ **Results:** _____

C-pap? (circle one) Yes / No **C-pap setting:** _____

Echocardiogram **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Heart Stress Test **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Heart Catheterization **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Breathing Test (PFT's) **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Upper Endoscopy (EGD) **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Colonoscopy **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Ultrasound of Gallbladder **Date:** _____ **Doctor/Location:** _____ **Results:** _____

DEXA Scan **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Women only

Mammogram **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Pap & Pelvic Exam **Date:** _____ **Doctor/Location:** _____ **Results:** _____

Men only

Prostate Exam **Date:** _____ **Doctor/Location:** _____ **Results:** _____

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PATIENT LAST NAME: _____

Current Medical Conditions *Check all that apply		
General	**Neurological**	**Genitourinary (GU)**
☐ Fever	☐ Numbness	☐ Urine Incontinence
☐ Chills	☐ Tingling	☐ Painful Urination
☐ Night Sweats	☐ Weakness	☐ Blood in Urine
☐ Fatigue	☐ Fainting	☐ Hesitancy
HEENT	**Hematological**	☐ Night-time Urination
☐ Headaches	☐ Easy Bruising	**Gastrointestinal (GI) / Abdominal**
☐ Vision Changes	☐ Easy Bleeding	☐ Pain
☐ Dizziness	☐ Blood Clots	☐ Nausea
Skin	**Musculoskeletal**	☐ Vomiting
☐ Rash	☐ Joint Pain or Swelling	☐ Diarrhea
☐ Jaundice	☐ Muscle Pain	☐ Constipation
☐ Ulcers (leg or sacrum)	**Cardiac**	☐ Bloody Stool
Pulmonary	☐ Chest Pain	☐ Heartburn/Reflux
☐ Cough	☐ Palpitations	☐ Difficulty Swallowing
☐ Wheezing	☐ Shortness of Breath w/ Activity	**Endocrine**
☐ Snoring	☐ Shortness of Breath w/o Activity	☐ Abnormal Hair growth
☐ Daytime Sleepiness	☐ Waking up short of breath	☐ High Blood Sugar
☐ Stop breathing in sleep	☐ Leg Swelling	☐ Thyroid Problems

Any additional medical information you want GHP to know: _____

_____

_____

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