WAYNE STATE UNIVERSITY
PHYSICIAN GROUP

New Patient Intake

LMP____/___/_____

Weight_____

Height_____

B/P _____/_____

Pulse_____

Resp._____

Date:___/___/_____

Patient Name_____ Birth Date____/___/_____

E-Mail Address_____

Contact Phone #_____

Allergies: ☐ None

☐ Latex ☐ Iodine ☐ IV Dye ☐ Penicillin ☐ Sulfa ☐ _____ ☐ _____

Medication List: *(example: Lipitor 20mg 1 x day)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy Name: _____

Address_____ City_____

Phone # _____

1

Reason for Visit: 1) _____ 2) _____

HEALTH MAINTENANCE:

Test/Exam	Last
Physical	_____
GYN/PAP	_____
Mamogm	_____
Colonoscpy	_____
Lipids	_____
Flu Shot	_____
Prostatev	_____
Tetanus	_____
(*Example 08/2001*)	

FAMILY HISTORY:

	Mother	Father	Sister	Brother
Alive & Well	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
_____	☐	☐	☐	☐

PAST MEDICAL HISTORY:

Check all that apply:

- ☐ **NO** Past Medical History
- ☐ Angina (chest pain)
- ☐ Arthritis: Rheumatoid/Osteo
- ☐ Asthma
- ☐ BPH (enlarged prostate)
- ☐ Blood Clots
- ☐ Cancer_____
- ☐ Cerebrovascular/ Stroke
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's/ Irritable Bowel
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD (acid reflux)
- ☐ Hypertension :↑ BP
- ☐ M.I./heart attack
- ☐ Osteoporosis
- ☐ Peptic/ Ulcer
- ☐ Renal/ Kidney
- ☐ Seizures
- ☐ Thyroid disease
- ☐ _____other
- ☐ _____other

PAST SURGICAL HISTORY:

Check all that apply:

- ☐ **NO** Past Surgical History
- ☐ Appendectomy (appendix removed)
- ☐ Back Surgery_____
- ☐ C-Section
- ☐ **Cardiac:** ☐ Angioplasty ☐ Angio w/stent ☐ Pacemaker ☐ CABG
- ☐ Carpal Tunnel
- ☐ Cataract
- ☐ Hernia Repair
- ☐ Joint Replacement_____
- ☐ Pacemaker
- ☐ Tonsillectomy
- ☐ Tubal Ligation/Hysterectomy
- ☐ Other:_____
- ☐ Other:_____

Patient Name: ____

SOCIAL HISTORY:

Language: Spoken ☐ English ☐ ________________

Education: Completed ☐ High School/ GED ☐ College ☐ PhD ☐ ___________

Employment: ☐ NO ☐ YES Employer:______________________________ ☐ Full Time ☐ Part Time

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Children: ☐ No ☐ Yes #_____children

With whom do you live? ____________________________ House ☐ Apt ☐ Other ☐ ________________

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Tobacco Use: Yes ☐ No ☐ Previous ☐ / Year Quit? ________

Passive Smoke Exposure (does anyone smoke in your home?) Yes ☐ No ☐

Alcohol Use: No ☐ Yes ☐ ____Daily ____ Weekly ____Monthly _____Yearly

Have you ever sought treatment for alcohol abuse? No ☐ Yes ☐ ______ Age

Family History of Alcoholism No ☐ Yes ☐ ____ (relationship)

Caffeine Use: None ☐ Soda POP ☐ ____x day Coffee ☐ ____x day Tea ☐ ____x day

Do you exercise? No ☐ Yes ☐ Type ______________________ #_________days/week

Religion: None ☐ Christian ☐ Jewish ☐ Muslim ☐ Buddhist ☐ Hindu ☐ Other ________________ ☐

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Street Drug Use: No ☐ Formerly ☐ Yes, currently ☐ Type_____________ How Often? ________

Have you ever sought treatment for drug abuse? No ☐ Yes ☐ ______Age when treated

Family History of Drug Use/ Abuse No ☐ Yes ☐ _______________________(relationship)

Psychiatric Hx: Have you ever had a psychiatric problem? No ☐ Yes ☐ ______________________(problem)

Family history of psychiatric problems: No ☐ Yes ☐ ______________(problem)________________(relationship)

Abuse/Violence: History of Child Abuse No ☐ Yes ☐ History of Domestic Violence No ☐ Yes ☐

Sexually Active? No ☐ Yes ☐ Heterosexual ☐ Homosexual ☐ #____Current Partners # _____lifetime

Condom Use: No ☐ Yes ☐ Birth Control Used:____________ History STDs: No ☐ Yes ☐ __________Type

wsufamilycare
Wayne State University Family Medicine at Crittenton

Patient-Provider Agreement discussed by physician and given to patient.

Staff Initials:

Date:

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND FINANCIAL RESPONSIBILITY

_____ _____

Print Patient Name (Last, First, Middle Initial) **Date of Birth**

PLEASE READ THIS ENTIRE GENERAL CONSENT PRIOR TO SIGNING

GENERAL CONSENT FOR MEDICAL SERVICES

I give permission to the physicians, employees, and other people who work for or represent Wayne State University Physician Group ("WSUPG") to provide me with health care services. These services could include things such as tests to determine whether I am sick, physical exams, surgery, and normal medical tests and procedures (e.g., blood tests or flu shots). My physician will help me decide what services or supplies I will need. I understand that WSUPG's physicians, employees and other people who work for or represent WSUPG make no promises about the type of results I may have from any of these medical services or treatments. I also understand that WSUPG helps train physicians and other health care professionals and that students and physicians-in-training might be involved in my medical care.

If my physician thinks I should have a specific medical or surgical procedure, I understand that my physician will describe this procedure to me and explain how it will help me. I also understand that my physician will tell me about the negative things that could happen as a result of the procedure, as well as any other types of treatments or procedures that could help me.

CONSENT TO RELEASE OF MEDICAL INFORMATION

I understand that my medical information may be used by WSUPG and shared with other people or organizations, such as my insurance company and other health care providers, if the information is needed for reasons related to treatment, payment, or health care operations. I also understand that WSUPG might need information from other people or organizations that have already given me medical care. If WSUPG needs that information to help give me medical care now, I give permission to those other people or organizations, such as a hospital, another physician, a managed care company, or a pharmacy, to give WSUPG any and all of my medical information, including any information that is on paper and in a computer. I understand that the WSUPG Notice of Privacy Practices has more information about how my medical information could be used and shared.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

In exchange for the medical services provided to me by WSUPG and its physicians, I agree to pay the WSUPG medical bills when they are due, even if the services I receive will not be paid for by my insurance company. If I am late in paying the WSUPG bills, and my account is given to a lawyer or a collection agency, I understand and agree that I will be responsible for paying the attorney's fees, court costs, and any financial penalties a court may award to help collect the amount(s) I owe to WSUPG. I understand that my insurance company may require that I get permission before I receive health care services from WSUPG, and it will be my responsibility to make sure I get this permission from the insurance company. When WSUPG bills me for medical services that are not paid for by my insurance, I agree that I will pay those bills to WSUPG.

ASSIGNMENT OF BENEFITS

I give WSUPG the right to receive all of the money that my insurance company would normally pay to me for any services I receive from WSUPG. I understand that any positive balance in my WSUPG account may be used by WSUPG to pay any amount I owe WSUPG for services I receive. If there is any amount remaining in my account after paying for what I owe, WSUPG will pay (refund) that amount to me.

PATIENT INITIALS: _____

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

By checking one of the boxes below, I am stating that:

☐ **Yes.** I have received a copy of the WSUPG Notice of Privacy Practices.

☐ I have been given the opportunity, but do not want to receive a copy of the WSUPG Notice of Privacy Practices.

CONSENT FOR BLOOD-BORNE INFECTIOUS DISEASE TESTING

I give permission to WSUPG to test me for an infectious disease in my blood. Infectious diseases that can be carried in the blood include hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"). I understand that the results of these tests will be put in my medical record and will be kept private. I also understand that if I do not give permission to WSUPG to do these tests, WSUPG cannot refuse to provide me health care services, just because I did not agree to have these blood tests.

☐ **Yes.** I give permission to WSUPG to test me for an infectious disease in my blood.

☐ No. I do **not** give permission to WSUPG to test me for an infectious disease in my blood.

CONTINUING AGREEMENT

I understand that the information in this General Consent form describes the relationship between me, patient, and WSUPG, the health care provider. I agree that the terms of this consent will continue to apply me and will remain in effect during the time that I am being cared for by WSUPG and its physicians, even though my treatment may involve more than one visit to WSUPG/its physicians and may last for a period of time.

By signing below, I am saying that I have read and understand this General Consent, and I agree that the terms will apply to me. I understand that I have a right to take away (withdraw) my consent/authorization at any time, unless WSUPG has already done something based on my earlier consent/authorization or WSUPG has the legal ability to do something without my consent/authorization.

_____ _____

[Signature of Patient or Patient's Legal Representative if Patient unable to sign] [Date]

Box below is for minors or legal representatives if patient cannot sign

_____
[Title of Legal Representative / Relationship to Patient unable to sign]

_____
[Address including street, city and zip code]

_____
[Phone Number]

Reason, if Patient is unable to sign:

☐ Physical/Mental Condition
☐ Minor (under 18 years old)
☐ Other:_____