Northpointe

Obstetrics & Gynecology, P.C.
Competent, compassionate health care for women.

Jon P. Lensmeyer, M.D.
Amanda Hurtubise, M.D.
Stacey Tremp, D.O.
Felicia Drouillard, M.D.
Jenny Giles, PA-C

WELCOME TO OUR OFFICE

Appointment Date: _____

Name _____

Birthdate _____ Marital Status _____ Maiden Name _____

Address _____ City _____ State _____ ZIP _____

Phone # _____ Cell? Yes☐ No☐ Work or Message Phone _____

If a child, parent's or guardian's name _____

Race: ☐White ☐Black ☐Asian ☐Indian/Alaskan ☐Pacific Island ☐Other/Multi

Ethnicity: ☐ Hispanic ☐ non-Hispanic

Patient's Employer _____Occupation _____

Social Security # _____

Please provide receptionist with all your insurance cards and Driver's License

Do you have Medical Insurance: Yes or No If no, how do you intend to pay? _____

Insurance Co. Name _____ Insured's DOB _____

Insured's Employer _____ Insured's Social Security # _____

Person financially responsible for this account? _____

Address _____ Phone: _____

What is the name of your family physician? _____
What is your preferred pharmacy? _____

In case of an emergency, please contact _____ Phone _____

Who may we thank referring you? _____ What will you be seen for today? _____

Does your lab work need to go to a specific lab? ☐Yes ☐No

Circle one: Quest Lab Corp McLaren Port Huron Lake Huron Med Center Other

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize NORTHPOINTE OB/GYN to release to my insurance company or other physicians upon my request any information regarding my treatment or diagnosis of my condition that they consider appropriate to obtain payment for service rendered to me. I also authorize and request such payments be made directly to Northpointe Ob/Gyn for any amounts due for such medical services. I understand that I am financially responsible for all charges whether or not paid by insurance.

NORTHPOINTE NO SHOW/CANCELLATION POLICY

Any patient that misses or cancels her appointment (the day of her appointment) three (3) times will be discharged from our practice and will be asked to seek care elsewhere.

I UNDERSTAND AND AGREE WITH THE ABOVE STATEMENTS AND POLICY

Patient's Signature _____Date _____

Patient Questionnaire

All information is treated as confidential unless you grant permission to release it. Please print your answers.

Name _____ **Date** _____

Birthdate _____ **Marital Status** _____**Referring Doctor** _____

GYNECOLOGIC HISTORY

	Yes	No	
Are you having regular monthly menstrual periods?			Date of last period:
Are you using a birth control method?			What type?
Are you now on or have you ever taken birth control pills?			
Do you regularly have a Pap smear?			Date of last Pap smear:
Have you ever had a sexually transmitted disease (STD)?			When?
Have you ever had a mammogram?			Date of last mammogram:
Have you ever been pregnant?			How many times?

PREGNANCY HISTORY (Please list the years of all your pregnancies and their outcomes (e.g., vaginal births, C-sections, miscarriage, ectopic pregnancy, etc.)

Year	Outcome	Complications

PAST AND PRESENT MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Asthma			Gall Stones			Poor Blood Clotting		
Angina			Goiter			Phlebitis		
Anemia			Gonorrhea			Rheumatic Fever		
Chronic Lung Disease			Heart Murmur as Adult			Stroke		
Cirrhosis of the Liver			Heart Attack			Stomach or Duodenal Ulcer		
Colon or bowel trouble			High Blood Pressure			Syphilis		
Diabetes			Hepatitis			Tuberculosis		
Emphysema			Kidney Infection			Thyroid Disease		
Enlarged Heart			Kidney Stones					
Other:								

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PRESENT MEDICATIONS (Include birth control pills and over the counter medications, example: Supplements)

MEDICATION	DOSE	HOW OFTEN

DRUGS YOU ARE ALLERGIC TO:

MEDICATION	REACTION (WHAT HAPPENED WHEN TAKEN)

OPERATIONS YOU HAVE HAD:

OPERATION	SURGEON	YEAR

HABITS	YES	NO	
Do you or did you ever smoke cigarettes?			How many packs per day?
Do you drink alcohol?			How many drinks per day?
Do you or did you ever use street drugs?			What drugs?
Do you regularly drink coffee?			How many cups per day?
During the past month, have you often been bothered by feeling down, depressed, or hopeless?			
During the past month, have you often been bothered by little interest or pleasure in doing things?			

FAMILY HISTORY List known conditions and diseases of any blood relative in your immediate family. Also include intellectual disability and birth defects.

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP