Welcome to Traverse Bay Internal Medicine

Your designated Patient-Centered Medical Home

Phone: (231) 486-5516 Fax: (231) 421-1439

The following is information that you will find helpful as you join our practice:

- We provide you with convenient 24/7 access to your medical records from the privacy of your computer or smart phone through our **Patient Portal.**

- We follow the guidelines for Patient-Centered Medical Home (PCMH) to make sure you receive well-coordinated, effective care that addresses your concerns and respects your wishes.

- ***First Visit***: print these forms www. traversebayim.com /forms/New Patient Packet

  Bring your insurance cards (required at every visit).
  Bring your completed new patient forms
  Bring your driver's license.
  Bring your current prescription bottles so we can record them accurately.
  Review your insurance coverage to determine your benefits BEFORE the appointment.
  Co-Pays and deductibles are due at the time of service.

- ***Our Location and Hours*:**

  - Address: 4977 Skyview Court, Traverse City, MI 49684
  - Office Hours: Monday - Friday 8:00 a.m. to 5:00 p.m.
  - Phone Hours: Monday - Friday 8:00 a.m. to 4:30 p.m. (closed 12:30 to 1:30 p.m.)

- Scheduling:

  - Call **231-486-5516** or request an appointment through your **patient portal** to schedule.
  - Please talk to the patient care coordinator to make appointments.
  - Speak with the clinical staff to discuss current health concerns.
  - Please call us if you are unable to keep your appointment.
  - If you need to be seen urgently, we will try to schedule you for a same day appointment.

- After Hours:

  - If you have an **Emergent** need, please call **911.**
  - If you have an **urgent** need, please call 231-486-5516 (press 1 to page the on-call provider)**.**

- Prescription Refills:

  - Please request your prescription refills at your office visits.
  - Requests through the **patient portal** are preferred (login access required).
  - We may take up to 48 hours to call in your refill—please plan accordingly.
  - If you have a controlled medication, please make sure you have read and understand our controlled substance policy.

- Financial Arrangements:

  - See our **Financial Policy** for complete details.
  - Charges not covered by your insurance are due at the time of service.
  - You are fully responsible for any portion of your bill that is denied or otherwise not paid by your insurance carrier.
  - Our billing office can work with you to set up a payment plan, if needed. Call 231-709-6196 to speak with one of our billing representatives.
  - Once a claim has been sent to your insurance, we will not change the billing.

Patient Information

Patient Name *(First, MI, Last)* ____

Preferred Name *(e.g. "Bob" or "Pat")*____

Former/Maiden Name *(if applicable)*____

Mailing Address ____

Phone Number(s) _________________ *(Home)* ____________________*(Cell)*

Date of Birth ______________________ **Social Security Number** _________________________

Email Address _____________________________ **Sex** _______________________________________

Primary Language ___________________________ **Translator Needed?** *(Yes or No)* ______________

Race *(Circle One)* *American Indian or Alaska Native *Asian *Native Hawaiian *Other Race

*Black or African American *White *Hispanic *Other Pacific Islander

Ethnicity *(Circle One)* *Hispanic *Non-Hispanic

Would you like information regarding available community resources and assistance programs?

If so, please list your interests/needs here : ____

____

Employer ____

Employer Phone Number and Location *(City, State)* ____

Retail Pharmacy Name/Location ____

Mail Order Pharmacy Name ____

Social History

Occupation/Employer ____

Hobbies____

Exercise: ____

Marital Status________________________ **Spouse's Name** *(If applicable)*______________________

Do you have children? If so, names/ages____

Do you have a place of worship? ____

Are you sexually active? ____

Tobacco Use

Are you a : ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Alcohol Use:

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If Yes, how often did you drink in the past year? ☐ Once per month or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

If Yes, how many drinks did you have on a typical day when you were drinking in the past year?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

If yes, how often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than once per month ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Family History

Family Member	**Status** *(Living or Deceased)*	**Age** *(Current age if alive)*	**Serious Health Conditions**
Father			
Mother			
Son(s)			
Daughter(s)			
Brother(s)			
Sister(s)			

Other concerns for hereditary illness:____

Medical History

Please list all of your current and past medical diagnoses

Current Diagnoses
Past medical problems

Surgical History

Date of Surgery	Surgeries Performed & Surgeon Name *(if known)*

Medications & Dosages

Medication	Dose	Frequency

Please list any allergies and the reaction: ____

____

____

____

Medical Care Team

Name of Previous Primary Care Physician (PCP) ____

Address/Location of Previous PCP ____

Phone Number of Previous PCP *(if known)* ____

Please list all other physicians you currently see *(both in-state and/or out-of-state)*

Physician Name	Specialty	Location *(City, State)*

Do you currently leave the Traverse City area for the winter months *(Yes or No)***?** ______________________

If yes, what is the approximate month of your departure from Traverse City? _________________________

If yes, what is the approximate month of your return to Traverse City? _______________________________

Gynecologic History

1. Sexual/Physical/Emotional abuse history: (if yes are you safe now?) ___________________________________

2. Specific gynecologic concerns? (Endometriosis/Fibroid/Infertility/PCOS/ Menopause)
____
____
____
____

3. Please circle if you have had any of the following cervical procedures:

LEEP Conization Cryotherapy TCA

4. Last Menstrual Period (date): **____**

5. History of Sexually Transmitted infections: ____

6. Are you currently using birth control? ____

-Do you want to discuss this ?____

7. Is there any any information you would like to share regarding your gender identity?

____

8. Date of last pap smear and results if known: ____

9. Date of last mammogram and results if known: ____

Obstetric/Pregnancy History

☐ I have never been Pregnant

Pregnancies	Number
Vaginal deliveries	
c-section deliveries	
Induced abortion	
Spontaneous abortion (miscarriage)	
Ectopic pregnancy	
Fetal demise	