

## It's so nice to see you again!

<p style="text-align: center;"><b>You are here today for:</b></p> <p>(circle) Annual Exam <b>OR</b> Problem: (please list)</p> <hr/> <p><b>We can only address a specific GYN problem <i>OR</i> your preventative/annual exam today. We prefer to address your problems first and will schedule your annual for a later date, but it is your choice. Please understand this is to assure maximum coverage for you. This is directed by insurance companies and NOT by Northpointe Ob/Gyn.</b></p>	<p><b>Name:</b> _____</p> <p><b>DOB:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>City/Zip Code:</b> _____</p> <p><b>Contact Number ( )</b> _____</p> <p><b>Alternate # ( )</b> _____</p>
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**Marital Status:**  Married  Single  Partnered  Divorced  Living together Partners Name: \_\_\_\_\_

**Are you covered under your someone else's insurance?**  Yes  No - **If Yes**, Insured Employer \_\_\_\_\_

Insured SS # \_\_\_\_\_ Insured DOB: \_\_\_\_\_

If no, or both - Your Employer: \_\_\_\_\_

**Insurance Carrier/Company** \_\_\_\_\_ \*Please provide receptionist with your insurance card.

**Race:**  Caucasian  African-American  Latino  Asian  Indian/Alaskan  Pacific Island  Other/Multi

**Ethnicity:**  Hispanic  Non Hispanic

**What is the name of your family physician?** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Since your last complete exam here, have you had any:**  Yes  No If yes, describe:

New Medical Problems? (non-GYN)  Yes  No

Surgeries?  Yes  No

Change in family history?  Yes  No

Plans to attempt pregnancy **THIS** years?  Yes  No

During the past month, have you often been bothered by feeling down, depressed, or hopeless?  Yes  No

During the past month, have you often been bothered by little interest or pleasure in doing things?  Yes  No

When did your last menstrual period begin? \_\_\_\_\_

### Release of Information and Assignment of Benefits

I authorize **Northpointe Ob/Gyn** to release to my insurance company or other physicians, 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.

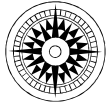
### Northpointe No Show/Cancellation Policy

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

**The above information is accurate to my knowledge. I understand and agree with the above statements and policy.**

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Does your lab work/Pap smear need to go to a particular lab? (Choose)	<b>Labcorp</b>	<b>Quest</b>	<b>McLaren Port Huron/PHH</b>	<b>Lake Huron Medical/Mercy</b>
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*Northpointe*

**Obstetrics & Gynecology, P.C.**

*Competent, compassionate health care for women.*

**Karen L. Niver, M.D.  
Jon P. Lensmeyer, M.D.  
Amanda Hurtubise, M.D.  
Stacey Tremp, DO  
Jenny Giles, PA-C**

**1206 Washington Avenue, Port Huron, MI 48060  
(810) 984-3100**

### HIPAA RELEASE

I give Northpointe Ob/Gyn authorization to release information regarding my health to the following people: (i.e., spouse, siblings, parents, etc.)

Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If our office cannot reach you personally, may we leave protected health information (i.e. Test results, appointment dates returned messages, etc.) by the following methods:

Email Address: \_\_\_\_\_

With a family member      Yes       No

Home answering machine:      Yes       No

Cellular phone voice mail:      Yes       No       Cell phone (    ) \_\_\_\_\_

By mail to home address:      Yes       No

Print Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_