It's so nice to see you again!

You are here today for:	**Name:** _____
(circle) Annual Exam **OR** Problem: (please list)	**DOB:** _____
_____	**Address:** _____
_____	**City/Zip Code:** _____
We can only address a specific GYN problem *OR* 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.	**Contact Number** ( )_____
	Alternate # ( ) _____

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)	**Labcorp**	**Quest**	**McLaren Port Huron/PHH**	**Lake Huron Medical/Mercy**

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: _____