Northpointe

Obstetrics & Gynecology, P.C.

Competent, compassionate health care for women.

Karen L. Niver, M.D.
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1206 Washington Avenue, Port Huron, MI 48060
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WELCOME TO OUR OFFICE

Appointment Date: _____

Name _____Preferred Name:_____

Birthdate _____ Maiden Name _____ Sex/Gender _____

Address _____ City _____ State _____ ZIP _____

Phone # _____Cell? Yes☐No☐ OK to leave a message? Yes☐No☐ Work #_____

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

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

Ethnicity: ☐ Hispanic ☐ Non Hispanic

Patient's Employer _____Occupation _____

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: _____

List all physicians who care for you? _____

In **case of an emergency**, please contact _____ Phone _____

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

Preferred Pharmacy: _____ City: _____

Does your lab work need to go to a specific lab? ☐Yes☐No **Circle one:** Quest/Lab Corp/McLaren Port Huron/Mercy Hospital/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 _____ **Birthdate** _____

GYNECOLOGIC HISTORY

Last Menstrual Period	Last Pap Smear Result:
Are you sexually active now or in the past? **YES NO**	Date of Last Mammogram
Are you sexually active with men/women/both? (circle)	If Menopausal, at what age:
Ever diagnosed with a sexually transmitted disease (STD)? If yes, what type:	If needed, what type of Birth Control are you on?
Are you currently pregnant or planning: **YES NO**	Have you ever taken hormone replacement: **YES NO**
Do you feel safe at home?: Yes or No	Language spoken most often:

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

How many times have you been pregnant?

Year	Outcome	Complications

PAST AND PRESENT MEDICAL HISTORY

General	Yes	No	General	Yes	No	Gynecology	Yes	No
Asthma			High Blood Pressure			Ovarian Cyst		
Anemia			Hepatitis			Fibroids		
Alcoholism			Kidney Infection			Abnormal Pap		
Caner-Type			Kidney Stones			Hysterectomy		
Chest Pain			Osteoporosis			Syphilis		
Colon or bowel trouble			Poor Blood Clotting			Herpes		
Diabetes			Rheumatic Fever			Frequent Yeast Infection		
Depression/Anxiety			Stroke			Frequent Bacterial Vaginosis		
Enlarged Heart			Stomach or Duodenal Ulcer			Gonorrhea		
Gall Stones			TB			Trichomonas		
Heart Murmur as an Adult			Thyroid Disease			Chlamydia		
Heart Attack						Genital Warts		
Other:								

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

MEDICATION	STRENGTH	HOW OFTEN	MEDICATION	STRENGTH	HOW OFTER

DRUGS YOU ARE ALLERGIC TO:

MEDICATION	REACTION (WHAT HAPPENED WHEN TAKEN)

VACCINATION/PREVENTION – If YES, when

Tetanus:	**YES / NO / Unknown**	Hepatitis A Vaccine:	**YES / NO / Unknown**
Pneumo Vax	**YES / NO / Unknown**	Shingles	**YES / NO / Unknown**
HPV-Gardasil	**YES / NO / Unknown**	COVID	**YES / NO / Unknown**
Tetanus / TDAP	**YES / NO / Unknown**	Tested for Rubella	**YES / NO / Unknown**
Varicella	**YES / NO / Unknown**	Yearly Flu Shot	**YES / NO / Unknown**
Bone Density- If yes, when		Colonoscopy or Cologuard	

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 recreational or illegal 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

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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: _____