



Obstetrics & Gynecology, P.C.

Competent, compassionate health care for women.

Karen L. Niver, M.D.
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Stacey Tresp, DO
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1206 Washington Avenue, Port Huron, MI 48060
(810) 984-3100

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 Page 2

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

MEDICATION	STRENGTH	HOW OFTEN	MEDICATION	STRENGTH	HOW OFTEN

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

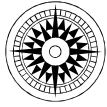
HABITS

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: _____