



Obstetrics and Gynecology

Joann M. Smith, M.D.

Dear Patient,

Welcome to Laurel Women's Medical Group! Enclosed you will find a patient registration form and health questionnaire. Please complete these forms and bring them with you to your first appointment. Also, please bring your insurance card as well as driver's license (or other form of picture identification). If your insurance requires any referral or authorization form, please provide these as well on your first visit.

Our office address is 36880 Woodward Avenue, Bloomfield Hills, Michigan 48304. We are located on the east side of Woodward Avenue, just south of Big Beaver Road (16 Mile). We are in Suite 201. There are marked designated parking spots located in the parking lot behind the building for patients of Dr. Smith. If you find you are unable to keep a scheduled appointment, we ask that you please call our office at (248) 642-7710 as soon as possible.

In an effort to protect our obstetrical patients from illness, as well as preventing children from injury, it is our policy that children are not allowed in the office. If you are unable to make child care arrangements during the time of your appointment, please reschedule your appointment for a convenient time when arrangements can be made.

Please contact our office if you have any questions, need assistance with directions or have any concerns. We look forward to meeting with you soon.

Sincerely,

Laurel Women's Medical Group

PATIENT NAME _____ BIRTHDATE _____

HOME ADDRESS _____

STREET APT# CITY STATE ZIP

HOME PHONE() _____ WORK() _____ CELL() _____ EMPLOYER

NAME _____ OCCUPATION _____ EMPLOYER

ADDRESS _____ (STREET CITY STATE ZIP)

SOCIAL SECURITY # _____ - _____ - _____ MARITAL STATUS S M D W

EMERGENCY CONTACT NAME & PHONE _____

SPOUSE/GUARDIAN INFORMATION

SPOUSE NAME _____ GUARDIAN NAME (IF MINOR) _____

BIRTHDATE _____ SOCIAL SECURITY # _____ - _____ - _____

EMPLOYER _____ PHONE # () _____

ADDRESS _____ (STREET CITY STATE ZIP)

INSURANCE INFORMATION BLUE CROSS BLUE SHIELD: SUBSCRIBER

NAME _____ GROUP # _____

COVERAGE CODE _____

CONTRACT# _____ EFFECTIVE DATE _____

MEDICARE: BENEFICIARY NAME _____

MEDICARE CLAIM NUMBER _____ EFFECTIVE DATE _____

PRIVATE INSURANCE COMPANY: _____

SUBSCRIBER NAME _____ CONTRACT # _____ POLICY # _____

INSURANCE CLAIMS ADDRESS _____

PHONE # _____ EFFECTIVE DATE _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

By signing below, I authorize Laurel Women's Medical Group to release the medical information necessary to process my insurance claims and authorize payment benefits directly to them. I will be responsible for charges not covered by my insurance carrier as well as any applicable co-pays and deductible. I also authorize LWMG to correspond or confer with my primary care physician regarding my treatment.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

I have received a copy of the Notice of Privacy Practices.

SIGNATURE _____ DATE _____

**Health History Questionnaire
Laurel Women's Medical Group**

Name: _____ Phone: (_____) _____

Age: _____ Birthdate: _____ Date of last period (first day) _____

What is the purpose of your visit today? _____

Gynecology History—please fill in or circle your response:

- At what age did you get your first period?..... _____
- How often do you get your period?..... Every _____ days
- How long do your periods last?..... _____ days
- How many pads/tampons do you use on the **heaviest** day?..... _____
- Is there any spotting between periods?..... Yes No
- Is there any significant pain with periods?..... Yes No
- Is there any lower abdominal pain at other times of the month?..... Yes No
- Is there any spotting or bleeding after intercourse?..... Yes No
- Is there any problem with sexual function?..... Yes No
- Are there any breast masses or lumps?..... Yes No
- Is there any breast discharge?..... Yes No
- Are there any urinary complaints? (burning, loss of urine, urgency)..... Yes No
- Have you ever had an abnormal Pap smear result?..... Yes No
- Have you ever had an abnormal mammogram?..... Yes No
- Do you have a history of any venereal diseases?..... Yes No
- Do you have any other problems or concerns not mentioned above?..... Yes No

What is your current method of birth control? _____

If you answered "yes" to any of the above questions, please explain: _____

Obstetrical History-please list all pregnancies, their outcomes and any complications:

Year	Length of preg.	Length of labor	Vaginal/C-section	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

General Medical History—please indicate if you have a history of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Anesthetic reaction | <input type="checkbox"/> Drug dependency | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Angina/chest pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Phlebitis/blood clots |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Stroke/mini-stroke |
| <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Bronchitis/Pneumonia | <input type="checkbox"/> Hepatitis/liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cirrhosis of liver | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other (_____) |

Family History—please indicate if any family members (parents, grandparents, siblings, children) have the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Other Cancer | <input type="checkbox"/> Heart disease |

Surgical History/Hospitalizations—please list all surgical procedures and hospitalizations (excluding childbirth):

Year	Reason for Hosp/Surgical Procedure	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication allergies—please list both the medication and the reaction below:

- Medication _____ Reaction _____
- Medication _____ Reaction _____
- Medication _____ Reaction _____

Current Medications (including over the counter medications, herbs and vitamins):

Medication	Strength	How often?	What is it for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal Habits

- Do you smoke cigarettes? Yes No How many per day? _____
- Do you drink alcohol? Yes No How much per day/week? _____
- Do you use recreational drugs? Yes No What drug do you use? _____
How often? _____
- Do you exercise regularly? Yes No Activity? _____
How often? _____

If there are any concerns regarding your visit, or aspects of your health history that were not covered above, please explain below: _____

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT JOANN M. SMITH, M.D.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees. This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

- (1) make sure that medical information that identifies you is kept private;
- (2) give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- (3) follow the terms of the Notice that is currently in effect.

How this Office May Use and Disclose Your Medical Information

The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

For Treatment. We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identify of the specific patients.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement. We may release medical information about you if required by law when asked to do so by a law enforcement official.

Coroners and Medical Examiners. We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Your Rights Regarding Your Medical Information:

You have the following rights regarding the medical information this office maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy your medical information with the exception of any psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing to Laurel Women's Medical Group. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact your physician.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office. To request an amendment, your request must be made in writing and submitted to your physician. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- (a) Was not created by us;
- (b) Is not part of the medical information kept by this office;
- (c) Is not part of the information which you would be permitted to inspect and copy; or
- (d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. To request this accounting of disclosures, you must submit your request in writing to Laurel Women's Medical Group. Your request must state a time period which may not be longer than six years and may not include dates before February 26, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure we make of your medical information. *We are not required to agree to your request for a restriction.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Laurel Women's Medical Group.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Laurel Women's Medical Group. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact Joann M. Smith, M.D at (248) 642-7710.

Revisions to This Notice

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you visit the office we will offer you a copy of the current Notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact Joann M. Smith, M.D. 36880 Woodward Avenue, Suite 201 Bloomfield Hills, Michigan 48304.

All complaints must be submitted in writing.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Other Uses of Medical Information

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.