Lakes Medical Center
2300 Haggerty Road, Suite 1010
West Bloomfield, MI 48323
(248)668-0900 * Fax: (248)926-9112

INTERNAL MEDICINE
& Primary Care Specialists

University Park
36650 Five Mile Rd, Suite 106
Livonia, MI 48154

Today's Date: _____ Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Fax: _____

Cell Phone: _____ E-Mail: _____

Patient's Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I give my permission to discuss my medical status with:

Name: _____ Relationship: _____

Phone: _____ Address: _____

Name: _____ Relationship: _____

Phone: _____ Address: _____

Preferred Pharmacy Name: _____ City: _____

Cross Roads: _____

Phone: _____ Fax: _____ Zip Code: _____

Patient Portal Agreement

The online patient portal is designed to improve physician and patient communication. After you are registered you will be able to do the following via the Patient Portal: Review your laboratory results, medical summary, medication list, treatment history, and visitation dates. The following **will not** be accepted through the patient portal: Requests for medical advice or medication refills. These requests must be made via office visit. Please call the office to schedule your appointment.

By providing your email address above you are providing consent to receive communication as outlined.

You will receive an email form patientfusion.com or practicefusion.com with instructions for signing up for the portal.

_____ _____

Patient Signature, Guardian (if a minor) or Responsible Party **Date**

_____ _____

Witness **Date**

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Medications

Name	Dose / Strength	Frequency (how often do you take it?)

Allergy	Reaction

Specialist Names	Specialty	Diagnoses

_____
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PAST MEDICAL HISTORY

☐ ADD/ADHD	☐ Cancer	☐ Head Injury	☐ High Cholesterol	☐ Psoriasis
☐ Anemia/Sickle Cell	☐ Cataracts	☐ Headaches/Migraines	☐ Kidney Disease/Stones	☐ Rheumatic Fever
☐ Allergies	☐ Chicken Pox	☐ Heart Attack	☐ Meningitis	☐ Seizure Disorder
☐ Aortic Aneurism	☐ Compression Fracture	☐ Heart Disease	☐ Neck Pain/Injury	☐ Shingles
☐ Arthritis/Lupus	☐ Diabetes (Sugar)	☐ Heart Murmur	☐ Neurological Problems	☐ Skin Disease
☐ Asthma	☐ Depression/Anxiety	☐ Hearing Problems	☐ Pancreas Disease	☐ Stomach Problems/Ulcers
☐ Back Pain/Injury	☐ Emphysema	☐ Hemorrhoids	☐ Pneumonia	☐ Stroke/CVA
☐ Bleeding Tendencies	☐ GERD	☐ Herniated/Disc Disease	☐ Polio/MS	☐ Thyroid Problems
☐ Blood Clots	☐ Glaucoma	☐ Hepatitis/Liver Disease	☐ Psychiatric Problems	☐ Tuberculosis
☐ Bronchitis	☐ Gout	☐ High Blood Pressure	☐ Prostate Problems	☐ Other _____

PAST SURGICAL HISTORY

☐ Adenoidectomy _____	☐ Cholecystectomy/Gallbladder____	☐ Hysterectomy (Total/Partial)_____	☐ Tubal Ligation _____
☐ Appendectomy _____	☐ Coronary Bypass _____	☐ Joint Repair _____	☐ Vasectomy _____
☐ Bariatric Surgery	☐ Glaucoma Surgery _____	☐ Tonsillectomy _____	☐ Wisdom Teeth _____
☐ Cataract Surgery ____	☐ Hernia Repair _____	☐ _____	☐ _____

Born in _____ Lived in USA since _____ Countries Traveled to _____

SOCIAL HISTORY / HAVE YOU EVER?

			Amount/Day	Years	Quit Date
Tobacco use	☐ Yes	☐ No			
Cigarettes			_____	____	_____
Cigar			_____	____	_____
Chewing tobacco			_____	____	_____
Ecigs/Vape			_____	____	_____
Interest to quit	☐ Yes	☐ No	_____	____	_____
Alcohol use:	☐ Yes	☐ No			
Beer			_____	____	_____
Wine			_____	____	_____
Liquor			_____	____	_____
Caffeine use:	☐ Yes	☐ No			
Soda			_____	____	_____
Coffee/tea			_____	____	_____
Pills			_____	____	_____
Street Drug use:	☐ Yes	☐ No			
Cocaine			_____	____	_____
Marijuana			_____	____	_____
Other _____			_____	____	_____
IV Drug Use _____			_____	____	_____

FAMILY HISTORY/AGES

↑ = Alive ↓ = Deceased

	Father ☐ Age: _____	Mother ☐ _____	Brothers ☐ _____	Sisters ☐ _____
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer _____	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐
Bleed/Clotting Disorder	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Anesthesia Complications	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Other _____	☐	☐	☐	☐
# Children _____	Sons _____	Daughters _____		
# Grandchildren _____				

Currently Live: ☐ Alone X ____yrs ☐ With friends X____yrs ☐ With family X _____ yrs ☐ With significant other X _____yrs

Marital Status: ☐ Married X ___ ☐ Separated X_____ ☐ Divorced X _____ ☐ Widowed X ____ yrs ☐ Never Married

Sexual Preference: ☐ Either ☐ Male ☐ Female Request STD screen today? ☐ Yes ☐ No

Sexual Partners include: Male ☐ 1 ☐ 2 ☐ 3 ☐ 4+ Female ☐ 1 ☐ 2 ☐ 3 ☐ 4+ Current ☐ Zero ☐ 1 ☐ 2+

Exercise: ☐ Regularly ☐ Occasionally ☐ Never Exercise type: _____ Diet type: _____

Seatbelts: ☐ Regularly ☐ Occasionally ☐ Never Education: _____

Helmets: ☐ Regularly ☐ Occasionally ☐ Never Job: _____

Pets: ☐ Dogs ☐ Cats ☐ Birds ☐ Other _____ ☐ Armed Forces _____ Years _____

Breast Self-exam ☐ Regularly ☐ Occasionally ☐ Never Last menstrual period: _____ ☐ History of abnormal PAP

Testicular Self-exam ☐ Regularly ☐ Occasionally ☐ Never Menarche Age X Cycle X Days _____/_____/_____

_____

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Health Maintenance:

Immunizations	(If applicable) up to date ☐ Yes ☐ No	Last colonoscopy	Date: _____
Last mammogram	Date: _____	Last bone density	Date: _____
Last pap smear	Date: _____	Last chest x-ray	Date: _____

GENERAL:	YES	NO
Weakness	☐	☐
Fatigue	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Changes in		
Weight	☐	☐
Appetite	☐	☐
Sleep	☐	☐

EYES:		
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Eye Redness	☐	☐
Excessive Tearing	☐	☐
Blurring or Spots	☐	☐
Loss of Vision	☐	☐
Last Eye Exam _____		

EARS:		
Hearing Loss/Decline	☐	☐
Ringing	☐	☐
Drainage/Type ___	☐	☐
Vertigo/Dizziness	☐	☐
Use Hearing Aide	☐	☐

NOSE/THROAT/SINUSES:		
Loss of Smell	☐	☐
Nosebleeds	☐	☐
Sore Throats	☐	☐
Hoarseness	☐	☐
Postnasal Drip	☐	☐
Snoring	☐	☐

MOUTH:		
Dentures	☐	☐
Bleeding Gums	☐	☐
Toothache	☐	☐
Loss of Taste	☐	☐
Last Dental Exam _____		

LUNGS:		
Cough	☐	☐
Wheezing	☐	☐
Shortness of Breath	☐	☐
Spitting up Blood	☐	☐
Positive TB Test	☐	☐

HEART/VASCULAR:	YES	NO
Chest Pain	☐	☐
Palpitations	☐	☐
Easy Fatigue	☐	☐
Ankle Swelling	☐	☐
Wake Short of Breath	☐	☐
Clots/Where_____	☐	☐
Blood Transfusion	☐	☐
Irregular Heartbeats	☐	☐
Last ☐Stress Test ☐Echo _____		

GASTROINTESTINAL:		
Abdominal Pain	☐	☐
Heartburn	☐	☐
Difficulty Swallowing	☐	☐
Vomiting	☐	☐
Blood in Stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Belching/Burping	☐	☐
Flatulence/Passing Gas	☐	☐

URINARY:		
Awaken to Urinate X ___	☐	☐
Strain to Urinate	☐	☐
Painful Urination	☐	☐
Blood in Urine	☐	☐
Frequent Urination X ___	☐	☐
Hesitancy Urinating	☐	☐
Weak Urine Stream	☐	☐
Kidney Stones	☐	☐

SKIN:		
Itching	☐	☐
Rash	☐	☐
Color Change	☐	☐
Easy Bruising	☐	☐
Moles	☐	☐
Skin Cancer/Type:_____	☐	☐

NEUROLOGIC:		
Headache	☐	☐
Dizziness	☐	☐
Double Vision	☐	☐
Muscle Weakness	☐	☐
Numbness	☐	☐
Loss of Coordination	☐	☐
	☐	☐

JOINTS & BACK:	YES	NO
Pain _____	☐	☐
Swelling	☐	☐
Stiffness	☐	☐
Deformity	☐	☐
Fractures/ Site _____	☐	☐
	☐	☐

MUSCLES:		
Pain _____	☐	☐
Weakness	☐	☐
Twitching	☐	☐

ENDOCRINE:		
Hair Loss	☐	☐
Excessively Hot	☐	☐
Excessively Cold	☐	☐
Always Thirsty	☐	☐
Always Hungry	☐	☐

PSYCHOLOGICAL:		
Nervousness	☐	☐
Depression	☐	☐
Sleep Difficulty	☐	☐
Nightmares	☐	☐
Panic Attacks	☐	☐
Had Counseling/ yr _____	☐	☐

MALE:		
	☐	☐
Hernia	☐	☐
Discharge	☐	☐
Testicle Pain	☐	☐
Sexual Disease	☐	☐
Erectile Dysfunction	☐	☐
Infertility	☐	☐

FEMALE:		
	☐	☐
Vaginal Itching/Burning	☐	☐
Vaginal Discharge	☐	☐
Problem Periods	☐	☐
Intercourse Pain	☐	☐
Breast Lumps	☐	☐
Nipple Discharge	☐	☐
Menopause	☐	☐
Infertility	☐	☐

Clinician Signature: _____ Patient Initials: _____

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ADVANCE DIRECTIVE FOR HEALTHCARE

YOUR HEALTH CARE AGENT

Your health care agent can make health care decisions for you when you can not make decisions for yourself. You should pick someone that you trust. Talk to them about your wishes. Tell them that you are making them your agent in this advance directive.

I want this person to be my healthcare agent:

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

I want this person to be my alternate agent if the first person cannot do it:

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

I want my advance directive to start:

☐ When I cannot make my own decisions

☐ Now

☐ When this happens: _____

We have found that it is helpful to know a patient's decision regarding resuscitation well in advance of the need of such information. Please indicate your wishes on the form below and sign and date at the bottom. Your doctor will discuss this decision with you. It is also important that you let your family members know your wishes. This will help ease their minds during an emergency situation.

CODE STATUS:

_____ **Full Resuscitation** – (Full Code)

_____ **Do Not Resuscitate** – (No Code)

_____ _____
Patient Signature, Guardian (if a minor) or Responsible Party **Date**

_____ _____
Witness **Date**

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YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED

There is a $35.00 fee for all non-sufficient funds/closed account returned checks.

There is a $25.00 fee for appointments that are not kept without a prior cancellation.

Accounts that have been sent to the Collection Agency will have a 35% handling fee added to the amount previously owed.

A $45.00 fee will be charged to a patient's account for any personal interaction with a provider without an appointment.

THE NON-MEDICARE PATIENT
I authorize the release of all medical information which is pertinent to my medical care and necessary to process this claim. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, to Lawrence Dell, M.D.P.C. and Internal Medicine & Primary Care Specialists (IMPCS). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

THE MEDICARE PATIENT
I request that payment of authorized Medicare benefits be made to me or on my behalf to Lawrence Dell, M.D. P.C. for any services furnished to me by Lawrence M. Dell, M.D. P.C., IMPCS, or associate providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I, OR THE PERSON LEGALLY RESPONSIBLE FOR MY MEDICAL CHARGES, AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES I.E. CO-PAYS, DEDUCTIBLES AND NON-COVERED PROCEDURES.

I HAVE READ THIS INFORMATION, HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS REGARDING THE CONTENT AND UNDERSTAND IT.

I HEREBY AUTHORIZE Internal Medicine & Primary Care Specialists AND/OR their EMPLOYEE/ASSOCIATES TO EXAMINE ME AND MANAGE AND TREAT ANY MEDICAL ISSUES THAT MAY ARISE.

_____ _____
Patient Initials **Date**

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HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

_____ _____

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YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ _____

Patient Signature, Guardian (if a minor) or Responsible Party **Date**

_____ _____

Witness **Date**