

NEW PATIENT REQUEST

We are not accepting any patients requiring chronic pain management or psychiatric services. We do not prescribe narcotics.

New Patients with uncontrolled chronic or complex health concerns are required to participate in our care management program. Our care management program is based on a team approach between you, your provider and a care coordinator/manager in our office to provide & coordinate an individual plan to meet specified health goals. There may be an out of pocket cost for these services dependent on your individual insurance plan, please contact your insurance to determine any cost responsibilities.

Date: _____ Provider Requested: _____

How did you hear about us? _____

Patient Name: _____

Have you used any other names since birth? _____

Date of Birth: _____ Male Female

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

I DO specifically consent to receive telephone calls, short messages ("SMS") text messages or other messages made or delivered to the telephone number(s) I provide verbally and/or in writing to Northern Pines Health Center. I acknowledge that these calls may be made or delivered using an automatic dialing system and/or an artificial or pre-recorded voice made by Northern Pines Health Center or its business associates for purposes of treatment, payment and healthcare operations.

Primary Phone Number: _____ Secondary Phone Number: _____

Guardian Name and Date of Birth: _____ Patient SSN: _____

Married Single Divorced Currently Employed Yes No Retired

Patient Email Address: _____

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

Have you ever been discharged from another medical practice? Yes No

If yes, what is the name of the practice you were discharged from?

Why were you discharged? _____

Are you currently taking a controlled substance (Ultram, Norco, Percocet, Vicodin, Ritalin, Adderall, Vyvance or Benzodiazepines, such as Xanax, Klonopin, Ativan, Valium, etc)? Yes No

If yes, what is the name of the controlled substance(s): _____

Have you ever been treated for or have you ever been diagnosed with chronic pain requiring regularly scheduled controlled substances (Ultram, Norco, Percocet, Vicodin, etc)? Yes No

Do you use any street drugs, such as heroin, methamphetamines, cocaine or marijuana? Yes No

Do you have a medical marijuana card? Yes No

Do you plan to obtain a medical marijuana card? Yes No Unsure

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Have you ever been treated for or have you ever been diagnosed with a psychological disorder, such as psychosis, schizophrenia or personality disorders? Yes No

What medications are you currently taking:

What conditions are you currently being treated for or have been diagnosed with in the past?

As part of our new patient screening process we ask your permission to access your electronic medical record known as Powerchart. Northern Pines Health Center strives to ensure every patient receives appropriate, quality care. In an effort to ensure this, we use the information obtained from Powerchart to help determine whether our practice is a good fit for you. Northern Pines Health Center is HIPAA compliant and your medical information will be held in strict confidentiality.

AUTHORIZATION TO ACCESS PATIENT INFORMATION

I hereby authorize Northern Pines Health Center to access my electronic medical record, called Powerchart, to complete their assessment. I understand that the electronic medical record (EMR) is comprehensive and includes hospitalizations, medical and psychological diagnosis, labs, diagnostic tests and procedures. I also hereby authorize Northern Pines Health Center to access my MAPS report to verify any controlled substance prescriptions.

X _____ Date _____
Authorized Signature

Please mail, fax or drop off your completed form:

Mailing/drop off address: Fax:
Northern Pines Health Center (231) 269-4461
11293 N M37, Suite A
Buckley, MI 49620

For Office Use Only:

Appointment: Yes No

Provider Remarks:
