Northwest Michigan Health Services, Inc.

Patient Intake Information

Date:

General Information

First Name:	Middle Initial:	Last Name:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
County:	Birthdate:	Social Security #: _____- _____- _____	

Email address: Do you want to participate in our Patient Portal? ❑Yes ❑No

Home Phone: Work Phone: Cell Phone: *How did you hear about us?*

What is the best way to reach you? ❑ cell phone ❑ home phone ❑ text ❑ email ❑ other _____

Can we text appt reminders? ❑ Yes ❑ No

Marital Status? ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated

Employer: Occupation: Do you work ❑Full time ❑Part time ❑Unemployed ❑Retired

Emergency Contact

Name:		Relationship:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	

FQHC-Required Demographic Information

It is the policy of NMHSI to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Race: ❑White ❑Asian ❑ Black/African American ❑Native Hawaiian ❑Pacific Islander ❑Other:
❑Native American/ Alaska Native – Tribal Member: ❑ Yes ❑ No Descendent: ❑ Yes ❑No Name of Tribe:

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic or Latino ❑Other: _____ Preferred Language:

Are you a veteran? ❑ Yes ❑ No Are you homeless? ❑ Yes ❑ No Do you need an Interpreter? ❑ Yes ❑ No

Do you work in Agriculture? ❑Migrant Worker ❑Seasonal Worker ❑None

This Section to be Completed for Patients 18 Years of Age and Over

Sexual Orientation: ❑Straight ❑Bisexual ❑Lesbian/Gay ❑Something Else ❑Don't Know ❑Choose not to Disclose

Gender Identity: ❑Male ❑Female ❑Transgender Male (F→M) ❑Transgender Female (M→F) ❑Choose not to disclose ❑Other:

Income Information

Federal Regulations require that we report the *combined total* of all household members' income for those seeking care at NMHSI. We ask your cooperation in indicating the following: Total Number in Household_____ Your yearly combined household income is in which broad category below?

The yearly combined household income?
☐ 0 - $11,490 ☐ $11,491 - $23,265 ☐ $23,266 - $35,325 ☐ $35,326 - $47,385 ☐ $47,386 - $59,446 ☐ $59,447 - $79,259 ☐ $79,260 +

Even if you have insurance, you may qualify for NMHSI's sliding fee scale, which offers discounted fees for services.
Do you want to apply to see your qualifications? ❑ Yes ❑ No

Insurance Information

Do you currently have health insurance? ❑Yes ❑No Dental Insurance? ❑Yes ❑No
If no, we can schedule an appointment with our outreach and enrollment team to help you!

Name of Individual Responsible for the Bill:		Relationship:	
Subscriber No.:	Group No.:		
Policyholder's Name:	Birthdate:	Social Security #: - -	
Mailing Address:	City:	State:	Zip:

Pharmacy Name: _____City: _____Ph#:_____

Do you have paperwork about your end of life wishes? ❑Yes ❑No

If no, are you interested in speaking with the provider about your end of life options? ❑Yes ❑No

Signature: _____ Date: _____

If Guardian, print name: _____

NORTHWEST MICHIGAN Health Services Inc

Consent to Treat, Assignment of Benefits, and Authorization to Release Information for:
Patient Name: _____

Consent to Treatment: I, the undersigned, herby consent to and authorize all diagnostic and therapeutic treatment performed at Northwest Michigan Health Services, Inc. (NMHSI) if considered necessary or advisable in the judgment of NMHSI providers. I understand and consent to a blood draw (including but not limited to HIV, AIDS and hepatitis antibodies) if an employee or provider has had an accidental exposure to my body fluids. I understand that I can obtain the results of these tests from my provider who can explain them. I authorize release of data necessary to process the testing and insurance claim, and I understand there will be no costs to me for this test.

Consent for Treatment by an Intern: NMHSI and the University of Michigan School of Dentistry (UMSD) have entered into a Community Services Agreement for the provision of dental services to assist in the delivery of oral health care at its locations. I understand that my dental provider may be a dental intern working under the direct supervision of NMHSI providers.

Consent for Local Anesthetic: I hereby consent to receive local anesthesia and agree to notify my provider of any drug/alcohol use, any history of adverse effects from local anesthetic in the past, and if I begin to feel side effects. Possible side effects may include: light headedness, dizziness, rapid heartbeat, warmth, nausea, bruising, swelling, pain, paresthesia, permanent numbness, infection, soft tissue damage, nerve damage, trismus, allergic reaction, headache, difficulty breathing, death.

Assignment of Benefits: I hereby assign all medical, behavioral health, and/or dental benefits to which I am entitled, to NMHSI for services provided. This includes Medicaid, Medicare, private and group insurance, or other health plans. I also understand that if I do not assign benefits, I may be responsible for the full charge of all services. In addition, I understand that treatment may be obtained at my regular dental office rather than at a mobile dental facility, and that obtaining duplicate services may affect benefits received from private insurance, state or federal programs, or other third party providers of dental benefits.

Financial Responsibility: I accept ultimate financial responsibility for accounts with Northwest Michigan Health Services, Inc., whether paid by insurance or not. I understand any change in treatment may alter expected reimbursements from insurance and that the services of providers and other healthcare professionals may be billed separately from those of this facility. As a patient of Northwest Michigan Health Services, Inc. I consent to services for either the prevention of medical or dental conditions or for care of ones that exist. I accept responsibility to pay for this care according to the fees established.

Release of Information: I agree that NMHSI may disclose my medical, behavioral health, or dental records to any third party payers, including, but not limited to, health insurers, health care service plans, welfare agencies, and worker's compensation carriers. NMHSI will follow federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code. I am aware and agree that NMHSI and referring providers are authorized to share information with each other including financial and/or medical/dental/behavioral health records, information related to drug use, alcoholism, psychiatric care, or other diagnoses that may be concerned sensitive by some. This may be verbal or written information and the information may include name, age, sex, address, social security number, and dates of professional services provided. I may review the information disclosed upon reasonable notice. This consent for release of medical/dental/ behavioral health or financial information is subject to revocation at any time, except to the extent that action has already been taken.

HIPAA Compliance: I authorize NMHSI and/or any entity authorized by NMHSI including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address, and/or mailing address associated with my account. I further authorize the providers and/or staff at NMHSI to contact me and share personal health information in the following manner: (check all that apply)

- ☐ I authorize NMHSI to discuss my treatment results, health information, and/or instructions with my spouse/partner/other person listed here: _____
- ☐ If patient is unavailable, it's okay to leave a detailed message, including health information and/or instructions.

Notice of Patient Privacy Practices: The Notice of Patient Privacy Practices and the Patient Rights and Responsibilities are posted on our website at www.nmhsi.org for patients to review. Personal copies are also available by request. By signing below, I acknowledge that I have been made aware of the Notice of Patient Privacy Practices and the Patient Rights and Responsibilities for my review and have been offered a personal copy.

I have read and understand all of the above.

Signature of Patient/Guardian: _____ Date: _____

Print Guardian Name here: _____ Relationship: _____

Northwest Michigan Health Services, Inc.

Sliding Fee Scale Eligibility

Even if you have insurance, you may qualify for our discounted fees for services.

Need affordable Medical, Dental, or Behavioral Health Care?

We've got you covered!

The most you will pay per visit:	Plan A **$20 Medical $30 Dental**	Plan B **$30 Medical $40 Dental**	Plan C **$40 Medical $55 Dental**	Plan D **$55 Medical $75 Dental**	Plan E No Discount – you pay full charges
Family Size	Monthly Household Income	Monthly Household Income	Monthly Household Income	Monthly Household Income	Monthly Household Income
1	$0 - $1,041	$1,042 - $1,561	$1,562 - $1,926	$1,927 - $2,082	Greater than $2,082
2	$0 - $1,409	$1,410 - $2,114	$2,115 - $2,607	$2,608 - $2,818	Greater than $2,818
3	$0 - $1,778	$1,779 - $2,666	$2,667 - $3,288	$3,289 - $3,555	Greater than $3,555
4	$0 - $2,146	$2,147 - $3,219	$3,220 - $3,970	$3,971 - $4,292	Greater than $4,292
5	$0 - $2,514	$2,515 - $3,771	$3,772 - $4,651	$4,652 - $5,028	Greater than $5,028
6	$0 - $2,883	$2,884 - $4,324	$4,325 - $5,333	$5,334 - $5,765	Greater than $5,765
7	$0 - $3,251	$3,252 - $4,876	$4,877 - $6,014	$6,015 - $6,502	Greater than $6,502
8*	$0 - $3,619	$3,620 - $5,429	$5,430 - $6,695	$6,696 - $7,238	Greater than $7,238

*For family household units of more than 8 members, add $368.33 per month per additional person.

Plus, we can connect you to other resources that might be helpful:

- food
- housing
- transportation
- legal services
- clothing
- child care
- more!

Household Members Please list **ALL** members of the household.

Name ***Relationship to the patient*** ***Date of Birth*** ***Work Place*** ***FT/PT***

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Household Income Please list ALL sources of income for each member of the household.

Type of Income:	***Member 1:***	***Member 2:***	***Member 3:***	***Member 4:***
Employment (including tips)				
Unemployment Compensation				
MI Bridges Cash Assistance				
Spousal Support, Child support				
Pension				
Social Security				
Other				
TOTAL INCOME				

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am eligible for the sliding fee scale discount, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. It is the policy of this organization to provide equal opportunities without regard to race, color, and religion. **I am aware that if I do not provide proof of income within 30 days, that I may be billed for the full amount for the services provided.**

Signature:	Date:

(Proof of income includes: 1040, W-2, or 1 month of paystubs.) To arrange a payment plan, call Bev @ (231) 947-0351. Revised 2/26/2019

HEALTH HISTORY FORM

Date:

PERSONAL INFORMATION

PATIENT NAME: DOB: ( ) Male ( ) Female

PRIMARY CARE PHYSICIAN: Ph#:
Date last seen:
For what?

DENTAL HOME: Ph#:
Date last seen:
For what?

MEDICAL HISTORY *Have you had any of the following? (Please circle)*

GENERAL	**RESPIRATORY**	**GENITAL**	**HEMATOLOGIC**
Disability	Tuberculosis	STDs	Blood Disorders
Steroid Treatment	Sinus Problems	**REPRODUCTIVE**	Hepatitis
Cancer	Asthma	Pregnant *due:*	Anemia
Medical Radiation	**CARDIOVASCULAR**	**PERIPHERAL VASCULAR**	Measles/Mumps
Sores in mouth	High Blood Pressure	Stroke *side effects:*	Scarlet Fever
SKIN	Heart Disease	**MUSCULOSKELETAL**	Chicken Pox/Shingles
Tumors or growths	Pacemaker	Back Problems	AIDS or HIV
HEENT	Heart Murmur	Arthritis	**ENDOCRINE**
Fainting Spells	**GASTROINTESTINAL**	Artificial Joints	Diabetes
Epilepsy	Black Stools	**PSYCHIATRIC**	Thyroid Problems
Dizziness	Stomach Problems	Mental Disorder	Rheumatoid Arthritis
Headaches	Liver Disease	**List any surgeries & dates:**	**List allergies/reactions:**
Head Injuries	**URINARY**		
Glaucoma	Kidney Disease		
Hearing Loss	Blood in Urine		

GYNECOLOGICAL HISTORY

How many times have you been pregnant?

Date of last Pap smear:
Have you ever had an abnormal Pap? Y N
When: Diagnosis:

Date of last Mammogram:
Results:
Date of any Breast Biopsy:
Results:

List all medications / vitamins you are taking:

Have you ever taken any of the following? ( ) osteoporosis medication ( ) chemotherapy medication ( ) psoriasis medication ( ) blood thinners
Have you ever had to take a medication before dental treatment? Y N ( ) for tooth infection ( ) for health problem

SOCIAL HISTORY

Have you ever had drug/alcohol abuse? Y N ( ) current problem ( ) receiving treatment ( ) recovering

Do you feel safe at home? Y N

Do you use tobacco products? Y N __day X __yrs ( ) cigarettes ( ) vape ( ) chew

Do you use marijuana products? Y N ( ) smoke ( ) vape ( ) edibles

What do you drink throughout the day: Pop Diet Pop Coffee/Tea Juice Water Energy Drinks Alcohol ( )with meals ( ) between meals

How many times a day do you? Brush: Use Floss: Use Toothpicks: Use Mouthwash: Use Fluoride:

Any oral habits? ( ) finger sucking ( ) chewing ice ( ) other:

Any oral piercings? Y N ( ) metal ( ) Bioplast ( ) acrylic

DENTAL HISTORY

Are your teeth sensitive to: Hot Cold Biting Chewing Sweets

Do you clench or grind your teeth? Y N

Do you have pain/ popping/ or clicking in your jaw joints? Y N

Have you ever had an injury to your face or teeth? Y N

Have you had excessive bleeding after an extraction? Y N

Have you ever had a problem with anesthetic? Y N

Do you have any cultural traditions regarding dental care? Y N

Do you have any fear or anxiety with dental visits? Y N

Are you currently having dental pain? Y N

Do you have any other dental concerns? Y N

FAMILY HISTORY

Mother Living Age: or Age at Death:

Father Living Age: or Age at Death:

Has any member of your family (including children and parents) ever had any of the following? *(Please list family members below)*

Sisters	*Living age / Age at death*	Brothers	*Living age / Age at death*

Anemia: Diabetes: High Blood Pressure: HIV disease or AIDS:
Blood Disease: Glaucoma: Mental Illness: Other serious illness:
Cancer: Heart Disease: Stroke:

Patient/Guardian Signature: Date:

Print guardian name here: *Relationship:*

Revised 02/23/2017