Northwest Michigan Health Services, Inc.

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:*

Northwest Michigan Health Services, Inc.
Patient Intake Information

General Information

First Name:	Middle Initial:	Last Name:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
County:	Birthdate:	Email address:	

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

Home Phone:	Cell Phone:	Can we text appt reminders? ❑ Yes ❑ No

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

Do you authorize our staff to leave a voicemail regarding treatment, test results or other necessary information? ❑ Yes ❑ No

Emergency Contact

Name:		Relationship:
Home Phone:	Cell Phone:	Work Phone:

Sharing of Information: Do you authorize NMHSI to discuss your treatment results, health information, and/or instructions with your spouse/partner/other person listed below: ❑No ❑Yes: If yes, please list name(s) below:

1) _____ **2)** _____
(Print Name) (Relationship) (Print Name) (Relationship)

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:

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		Are you a refugee/asylum? ❑ Yes ❑ No

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

Sex: ❑Male ❑Female ❑Choose not to disclose

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: $_____

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

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

Preferred Pharmacy: _____

Signature:	**Patient/Guardian:**	**Date:**
	Print Guardian Name:	**Relationship:**

Northwest Michigan Health Services Inc

SLIDING FEE SCALE ELIGIBILITY

Form Instructions:

Step 1: Please list **ALL** members of the household, including yourself.
Step 2: Please list **ALL** sources of annual income for each member of the household.
Step 3: Please provide proof of income within **30 days**. Examples of proof of Income: **1040, W-2, or 1 month of paystubs.**
Step 4: Please sign form accordingly.

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

Patient Name:______________________________________

STEP 1: Household Members– Please list **ALL** members of the household, including **YOURSELF.**

	NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	WORKPLACE	FULL/PART TIME
1.		**SELF**			
2.					
3.					
4.					
5.					
6.					

STEP 2: Annual Household Income– Please list **ALL** sources of income for each member of the household.

Type of Income:	***Member 1 (You):***	***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	**$**	**$**	**$**	**$**

STEP 3: Proof of Income- Please provide proof of income within 30 days, or you may be billed for the full amount for the services provided. Bring your proof of income to your next 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	Annual Household Income		Annual Household Income		Annual Household Income		Annual Household Income		Annual Household Income
1	$0	$15,060	$15,061	$22,590	$22,591	$27,861	$27,862	$30,120	greater than $30,121
2	$0	$20,440	$20,441	$30,660	$30,661	$37,814	$37,815	$40,880	greater than $40,881
3	$0	$25,820	$25,821	$38,730	$38,731	$47,767	$47,768	$51,640	greater than $51,641
4	$0	$31,200	$31,201	$46,800	$46,801	$57,720	$57,721	$62,400	greater than $62,401
5	$0	$36,580	$36,581	$54,870	$54,871	$67,673	$67,674	$73,160	greater than $73,161
6	$0	$41,960	$41,961	$62,940	$62,941	$77,626	$77,627	$83,920	greater than $83,921
7	$0	$47,340	$47,341	$71,010	$71,011	$87,579	$87,580	$94,680	greater than $94,681
8	$0	$52,720	$52,721	$79,080	$79,081	$97,532	$97,533	$105,440	greater than $105,441

*For family household units of more than 8 members, add $5,140 per annual per additional person. Effective 3/15/24 – 2/28/25

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.

STEP 4: Signature

Patient/Guardian: ______________________________________

Date: ______________________________________

Print Guardian Name/ Relationship: ______________________________________

***Revised:** March 2024*

Informed Consent for Telehealth/TeleDental Services

Today's Date: _____

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Purpose: Northwest Michigan Health Services, Inc. and the healthcare provider assigned to me will provide health care services through the use of live, two-way video (visual) and/or audio (sound) and other computer-based services.

I understand that the electronic services allow Provider to obtain information about my health status through electronic communications for the purpose of diagnosing and determining a treatment plan for certain non-emergency conditions.

I understand that the information provided or exchanged may be used for diagnosis; treatment plan development and review; and case management; and may include any or all of the following electronic communications: patient medical record documentation, live two-way video and audio files and transmission of images and other data.

Possible Risks: As with any use of technology, there are potential risks associated with the use of the electronic care services. I understand that these risks include, but may not be limited to, the following risks:

- Delays or errors in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- Information transmitted may not be sufficient to allow for appropriate medical decision making.
- Although precautions are taken to protect the confidentiality of information new security threats can develop. I understand that there may be other risks to the confidentiality and security of my personal information that neither Northwest Michigan Health Services nor I can anticipate at this time.

Patient Consent:

- I understand that the laws that protect privacy and confidentiality of health information also apply to telehealth, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities without my consent.
- I understand that this consent will expire (365) days from the date of my signature. However, I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I do not have to use Telehealth Services; it is my choice to use electronic services.
- I also understand that the Provider will document the services I receive in my Northwest Michigan Health Services, Inc. electronic medical/dental record.
- I understand that no results can be guaranteed or assured.
- I understand that insurance companies and third-party payers, including Medicare and Medicaid, may not pay for electronic visits. If my insurance company or third-party payor does not pay for an electronic visit, I understand that I am responsible for paying for the Telehealth or Video Visit.
- I understand that the Provider may terminate a Telehealth Visit if the Provider determines that my condition requires immediate in-person care, or otherwise determines that a Telehealth Visit is not appropriate to meet my healthcare needs.
- I agree that Providers *may not* be able to prescribe certain types of medications, including controlled substances. I agree that any prescriptions I receive from an electronic visit will be used only by me, for my healthcare needs.

I have read this document carefully and understand the risks and benefits of the electronic services and wish to obtain services through electronic visits.

Signature:	**Patient/Guardian:**	**Date:**
	Print Guardian Name:	**Relationship:**

NORTHWEST MICHIGAN HEALTH SERVICES INC

Consent to Treat, Assignment of Benefits, and Authorization to Release Information

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 agree to participate in Carequality, by allowing the exchange of my health records with other participating Carequality entities for continuation of care. 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.

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.

If patient is under the age of 18: Please complete Authorization for Treatment of Unaccompanied Minor

Authorization for Treatment of Unaccompanied Minor:

☐ **Yes** ☐ **No** **I hereby authorize Northwest Michigan Health Services, Inc to provide Medical and/or Behavioral Health treatment to the unaccompanied above-named minor child.**

☐ **Yes** ☐ **No** **I hereby authorize Northwest Michigan Health Services, Inc to administer childhood immunizations excluding Influenza (flu) and covid vaccines. I understand that a separate consent will be required for Influenza (flu) and covid vaccines.**

I have read and understand all the above.

Signature of Patient/Guardian:_____ Date:_____

Print Guardian Name:_____ Relationship:_____

NORTHWEST MICHIGAN Health Services Inc

Authorization to Request Health Information

NMHSI has 30 days to release records and they are processed in the order they are received. If you need them sooner than 30 days, please indicate the date they are needed by.

PATIENT NAME:_____

DATE OF BIRTH: _____ DAY PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RECEIVE INFORMATION FROM: →

Name:

Address:

Phone: **Fax:**

Northwest Michigan Health Services, Inc.
Medical Records Department
(231) 383-4800

☒ **6051 Frankfort HWY**
Benzonia, Mi 49616

☒ **F: (231)642-5285**
TO:

I authorize ☒ Verbal ☒ Written exchange of information from my health record as indicated below:

MEDICAL RECORDS/INFORMATION

- ☐ Last 3 Office Visits (Progress Notes & Medication List)
- ☐ Lab and Medical Imaging Records- *Last 2 years*
- ☐ Mammogram Results-Most Recent
- ☐ Thin Prep (PAP)- Most Recent
- ☐ Colonoscopy, FOBT/FIT, or Cologuard Results
- ☐ Immunization- Current Record
- ☐ Last Well Child Visit
- ☐ Newborn Screen
- ☐ Hospital/ER Discharge Notes- *Last 12 months*
- ☐ *Other, specify: _____

DENTAL RECORDS/INFORMATION

- ☐ Last 3 Office Visits (Progress Notes & Medication List)
- ☐ Dental Imaging Records/X-Rays- *Last 5 years*
- ☐ Hospital/ER Discharge Notes- *Last 12 months*
- ☐ *Other, specify:_____

Please send Imaging Records to the following email:
dentalrecords@nmhsi.org

PURPOSE OF DISCLOSURE:

☐ Transfer of Care ☐ Continuity of Care ☐ Insurance ☐ Personal Use

IF YOU *DO NOT WANT* TO RELEASE ANY OF THE FOLLOWING SENSITIVE INFORMATION IN THE CATEGORIES BELOW, CHECK THE BOX(ES) FOR CATEGORIES:

- ☐ Substance abuse treatment information (including alcohol/drug abuse) protected under the regulations in 42 code of Federal Regulation, Part 2.
- ☐ Mental health treatment records, psychological services and social services information.
- ☐ Serious communicable diseases and infections such as, Sexual Transmitted Infections, Tuberculosis, hepatitis B, Human Immunodeficiency Virus, and AIDS related information.

1. I understand that this authorization will expire (90) days from the date of my signature, unless I specify otherwise.
2. I understand that I may withdraw this authorization at any time by providing written notification. The withdrawal will be effective on the date of notification except to the extent action has already been taken as allowed by this authorization.
3. I understand that if the person or entity that receives the information is not a healthcare provider or health plan, covered by Federal Privacy Regulations or State Law, the information described above may be re-disclosed and no longer protected by those regulations.
4. I understand that Northwest Michigan Health Services, Inc. does not require this authorization as a condition for giving treatment, payment enrollment, or eligibility for benefits.

Signature of Patient/Guardian: _____ Date: _____

Print Name: _____ Relationship:_____

Northwest Michigan Health Services, Inc.

Name: _____ Date of Birth: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use √ to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
For office coding:	0	+_____	+_____	+_____
=TOTAL SCORE				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Northwest Michigan Health Services, Inc. Who did you see today?: _____

Date: _____

Patient Name: _____ Date of Birth: _____

PRAPARE SCREENING

Your home situation is important to your health.
Our team may follow up with you to offer services or resources based on your answers.

Money & Resources

What is your housing situation today?

- ☐ I have housing
- ☐ I do not have housing (staying with other, in a hotel, living outside on the street, on a beach, or in a park)
- ☐ I choose not to answer this question

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

What is the highest level of school that you have finished?

- ☐ Less than a high school degree
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question

What is your current work situation?

- ☐ Unemployed and seeking work
- ☐ Part time or temporary work
- ☐ Full time work
- ☐ I am a student/retired/disabled/unpaid care giver or unemployed and not seeking work
- ☐ I choose not to answer this question

In the past year, have you or anyone you live with been unable to get any of the following when it was really needed? Check all that apply

- ☐ I do not have problems meeting my needs
- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Child Care
- ☐ Medicine or any health care (medical, dental, mental health, or vision)
- ☐ Phone
- ☐ Other (please write in notes)
- ☐ I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
- ☐ No
- ☐ I choose not to answer this question

Social and Emotional Health

How often do you see or talk to people that you care about and feel close to? (For example: Talking to friends on the phone, visiting friends or family, going to church or club meetings)

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ More than 5 times a week
- ☐ I choose not to answer this question

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much
- ☐ I choose not to answer this question

Additional Questions

In the past year spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

Are you a refugee (escaping your home country due to war/natural disaster/other reasons)?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

What country are you from?

- ☐ United States
- ☐ Country other than the United States (Please write in notes)

  _____
- ☐ I choose not to answer this question

Do you feel safe physically and emotionally where you currently live?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I have not had a partner in the past year