GENERAL SURGERY

Michigan Avenue Medical Center | 577 Michigan Ave. Suite 202 | Holland, MI 49423 | **P** (616) 394-0673 | **F** (616) 394-9825 | lakeshorehealthpartners.com

844 S. Washington Ave. Suite 2700 | Holland, MI 49423 | **P** (616) 355-3820 | **F** (616) 355-3960

Welcome to our practice!

Thank you for choosing Lakeshore Health Partners for your healthcare needs.

Your appointment is scheduled on:

____

Date   Time   Provider

If for any reason you are unable to attend this appointment please contact us at least 24 hours in advance to reschedule.

Please complete the enclosed forms and return them to us in the envelope provided or fax them to our office at 616-394-9825. If there is not enough time to mail the completed forms back to us, please bring them with you to your first appointment.

Directions: We are located across from Holland Hospital at 577 Michigan Avenue. We are the red brick building on the hill.

We look forward to meeting you.

Sincerely,

Lakeshore Health Partners General Surgery

Daniel J. DeCook, MD, FACS | Brian N. Dishinger, MD, FACS | Jessica M. Hafner, DO

William R. Houskamp, MD, FACS | Jane E. Pettinga, MD, FACS | Stephen J. VanWylen, MD, FACS

This physician office is a department of Holland Hospital, a nationally recognized health care provider. Your care is integrated to better serve you and the community.

Lakeshore Health Partners
A Holland Hospital Physician Office

GENERAL SURGERY

Patient Information

(Please Print)

Appt Date and Time:	Appt Dr.
PCP:	Account No:

Demographic Information

Last Name:	First Name:	MI:	
Address:	DOB:	Age:	Sex:
City, State, Zip Code:			
Social Security No:	Marital Status:		
Home Phone:	Work Phone:		
Cell Phone:	Email:		
Employer Name:	Employer Address:		
Preferred Pharmacy:			
Race: American Indian Asian African American Caucasian Hispanic Other	Ethnicity: Hispanic Non-Hispanic Do not wish to report		
Language:			

Insurance Information
(Please give your insurance card(s) to the person at the front desk)

Person Responsible for Bill:	Address (If different from the patient):	Home Phone:		
Is this person a patient here? Yes No				
Primary Insurance:				
Subscriber's Name:	Subscriber's DOB:	Subscriber's SSN:	Policy Number:	Group Number:
Patients relationship to subscriber:				
Secondary Insurance:				
Subscriber's Name:	Subscriber's DOB:	Subscriber's SSN:	Policy Number:	Group Number:
Patient's Relationship to subscriber:				

In Case of Emergency

Name of Emergency Contact:	Relationship to Patient:	Contact Phone:

Lakeshore Health Partners
A Holland Hospital Physician Office

GENERAL SURGERY

Medical History Questionnaire

Date: ____________

Name: ______________________________
Occupation: __________________________
Height: ___________ Weight: _________
Marital Status: ______ # of Children: _____
Birthday: ________________ Age: _______
Pharmacy and Location Used: ___________
____
Medication Allergies: _________________
____
____
Latex Allergies: No Yes
List past surgical procedures and year (Ex. Appendectomy 1975)
____
____
____
____
____
____

	Medication	Directions	Dose
Ex:	Lasix	1 Twice Daily	40mg
	_________________	___________	_____
	_________________	___________	_____
	_________________	___________	_____
	_________________	___________	_____
	_________________	___________	_____

Do you use Aspirin regularly? ___________
What mg? ____________________________

Answer Yes or No

Are you a current smoker? No Yes
If yes: How many years have you smoked?_____________________
How many packs/day? ___________
Are you a former smoker? No Yes
Smoking Exposure? No Yes
Do you use recreational drugs? No Yes
If yes, how much?________________
Do you use alcohol? No Yes
If yes, how much? ______________
Do you use caffeine/coffee/tea/pop?
No Yes If yes, how much? _______

Condition	No	Yes
High Blood Pressure	No	Yes
Heart Disease-		
Angina	No	Yes
Heart Attack	No	Yes
Irregular Heartbeat	No	Yes
Heart Murmur	No	Yes
Rheumatic Disease	No	Yes
Diabetes	No	Yes
Lung Disease-		
Asthma	No	Yes
Emphysema	No	Yes
Pneumonia	No	Yes
Recent Bronchitis	No	Yes
Bleeding/Clotting Disorder	No	Yes
Psychiatric	No	Yes
Depression	No	Yes
Anxiety	No	Yes
Nervous System		
Stroke	No	Yes
Seizure	No	Yes
Gastrointestinal Disease		
Stomach Ulcer	No	Yes
Hiatal Hernia	No	Yes
Gallstones	No	Yes
Colitis	No	Yes
Diverticulitis	No	Yes
Kidney Disease	No	Yes
Infections	No	Yes
Stones	No	Yes
Cancer	No	Yes

What Type? ___________________
Thyroid No Yes
MRSA No Yes
Other Medical Problems No Yes
Please List: ____________________
____
____
____
____
____
____
____
____

Please Complete Back of Form

Lakeshore Health Partners
A Holland Hospital Physician Office

GENERAL SURGERY

Family History

Please check if any of your family members have the following:

Heart Disease	No	Yes	______________________
Diabetes	No	Yes	______________________
Colon Cancer	No	Yes	______________________
Colon Polyps	No	Yes	______________________
Thyroid Disease	No	Yes	______________________
Bleeding Disorder			______________________
Anemia	No	Yes	______________________
Clotting Disorder	No	Yes	______________________
Breast Cancer	No	Yes	______________________
Other Cancer	No	Yes	______________________
If yes, what type? ____________			______________________

Father

Age if living ______________

Age when deceased ______________

Cause of death ______________

Mother

Age if living ______________

Age when deceased ______________

Cause of death ______________

Siblings

How many brothers ______________

Age when deceased ______________

Cause of death ______________

How many sisters ______________

Age when deceased ______________

Cause of death ______________

Holland Hospital
PHYSICIAN OFFICES

CONSENT FOR THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all of your health information in our possession (collectively "Protected Health Information").

The uses and disclosure by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you, and so that this office can conduct its health care operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that this office has prepared and is furnishing to you today. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment," "payment," and "health care operations."

Lakeshore Health Partners participates in an organized health care arrangement with Brain + Spine Center, PLC, Holland's Bone & Joint Center and Western Michigan Urological Associates. The organized health care arrangements uses an integrated electronic medical record system. Participants in this integrated medical record system may use and disclose records for treatment, payment and health care operations purposes relating to their own patients, and as otherwise required by law or permitted by HIPAA, INCLUDING, IF APPLICABLE, ANY INFORMATION IN MY MEDICAL RECORDS RELATING TO HIV INFECTION OR ACQUIRED IMMUNODEFICIENCY SYNDROME (HIV/AIDS).

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES WILL BE MADE AVAILABLE TO YOU BY CONTACTING THE OFFICE MANAGER.

YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM TO TAKE WITH YOU.

______________________________ Patient Name	______________________ Patient Date of Birth
______________________________ Patient (Guardian) Signature/Relationship to Patient	______________________ Date
______________________________ Witness	______________________ Date

Holland Hospital
PHYSICIAN OFFICES

Financial Policy

Insurance
We will bill your insurance carrier according to our contract or as a courtesy to you, however payments for deductibles and copays are due at the time of service. This includes all office visits, procedures, and injections. If you do not have your copay with you, your appointment may be rescheduled. Please remember…your insurance coverage is a contract between *you* and *your insurance company* and **not** a substitute for payment. Failure to provide us with your Social Security number may make it impossible for us to speak to your insurance regarding your claim.

Prior Authorizations
Some insurance plans require prior authorization for procedures done in the office, this will be the patient's responsibility to check with their insurance prior to their visit to avoid possible higher deductible and copay charges.

Self-Pay Accounts / Plans We Don't Participate With
Self-pay accounts are patients that have no insurance coverage, have not met their deductible or are covered by insurance plans we do not participate with. Payment must be made at the time of service. If this is not possible, please discuss the situation with the billing department **before** your scheduled appointment.

No-show/Cancellation policy
We kindly ask that you provide 24 hours' notice if you are unable to keep a scheduled appointment. Failure to do so may result in a "No Show" fee charged to your account. Payment of this fee will be required prior to the rescheduling of a new appointment. Multiple missed appointments may result in discharge from our practice. Exceptions will be made on a case by case basis. Thank you in advance for your cooperation.

Collections
In the unlikely event that we require the services of a collection agency, a 25% surcharge will be added to your account.

Payment Methods
For your convenience, we accept the following methods of payment: Cash, Personal Check, Visa, MasterCard, Discover.

Authorization and Release

I authorize payment of medical benefits be made directly to Lakeshore Health Partners, Holland Hospital or its related entities. I understand the financial policy and accept the personal responsibility for payment of covered and non-covered services. I authorize the release of any medical or other information necessary to process my claims.

______________________________ Patient/Guardian Signature

____________________ Date

Medicare Information / Authorization		
Number	Primary? ☐Yes ☐No	Medicare Part B? ☐Yes ☐No

I request that payment of authorized Medicare benefits be made to Lakeshore Health Partners, Holland Hospital or its related entities. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Centers for Medicare and Medicaid Services or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement and benefits to be paid to Lakeshore Health Partners, Holland Hospital or its related entities for any services furnished to me until further notice. I authorize any holder of information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Centers for Medicare and Medicaid Services, or its agents.

______________________________ Signature

____________________ Date

Holland Hospital
PHYSICIAN OFFICES

Information Release

Patient Name: ____ DOB: ____________________

PLEASE NOTE: All of our patients are notified of upcoming appointments in our office via telephone by our automated reminder service.

AUTHORIZATION TO LEAVE MESSAGES

O **I DO** authorize the physicians and employees of Lakeshore Health Partners to **leave information** regarding appointment changes, laboratory results, x-rays, or other diagnostic tests at the following contact numbers/voicemail:

____

____

O **I DO NOT** authorize the physicians or employees of Lakeshore Health Partners to leave any information regarding appointments changes, laboratory results, x-rays, or other diagnostic tests on my answering machine/voicemail.

AUTHORIZATION FOR RELEASE OF INFORMATION

Confidentiality laws require us to obtain your written consent before we can discuss any of your information with your family member(s) or friend(s).

Please choose ONE of the following:

O I **DO NOT** authorize verbal information to be released to **any** individuals

O I **DO** authorize my information to be released to the following individuals:

Name	Relationship	Phone

Patient (Guardian) Signature:______________________________ Date:____________________