# SILVER PINE MEDICAL GROUP

## PATIENT INFORMATION

Date: _____

Please Print

Last _____ First _____ MI _____ Birth date _____ ☐ M ☐ F Sex _____ / / Social Security Number _____

Address _____ City _____ State _____ Zip _____

### Contact Numbers

Home Phone _____
Work Phone _____
Cell Phone _____

### Primary Language

☐ English ☐ Italian ☐ Polish
☐ Spanish ☐ Arabic ☐ German
☐ French ☐ Hindi ☐ Other
☐ Greek ☐ Japanese

### Marital Status

☐ Single ☐ Widowed
☐ Married ☐ Separated
☐ Divorced

### Race

☐ Caucasian
☐ Asian
☐ Native Hawaiian
☐ Native American / Alaska Native
☐ African American
☐ More than one race
☐ Other Pacific Islander
☐ Unreported/ Refused

### Ethnicity

☐ German ☐ Russian ☐ Native American
☐ Italian ☐ Serbian ☐ Spanish
☐ Greek ☐ Polish ☐ Portuguese
☐ Albanian ☐ English ☐ Other/Unreported

Employer _____ Occupation _____

Email Address _____

## INSURANCE HOLDER

☐ Check here if you, the patient, are the responsible party

Last _____ First _____ MI _____ Birth date _____ ☐ M ☐ F Sex _____ / / Social Security Number _____

Address _____ City _____ State _____ Zip _____

## RESPONSIBLE PARTY

Last _____ First _____ MI _____ Birth date _____ ☐ M ☐ F Sex _____ / / Social Security Number _____

Address _____ City _____ State _____ Zip _____

## EMERGENCY CONTACT *(Please Print)*

Name _____ Phone # _____ Relationship _____

## REFERRED BY

☐ Family or Friend
☐ Beaumont Hospitals
☐ Advertisement (please specify) _____
☐ Internet
☐ Urgent Care
☐ Other Physician (please specify) _____
☐ Other (please specify) _____

*Please see reverse side*

# PATIENT HISTORY

15 Years and Older

## MEDICAL HISTORY

- ☐ Hypertension (high blood pressure)
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Diabetes
- ☐ Heart / Palpitations / Heart Attack
- ☐ Cancer: _____
- ☐ Lung / Asthma
- ☐ Thyroid Problem
- ☐ Joint Pain
- ☐ Eye / Vision
- ☐ Depression / Anxiety
- ☐ Stomach
- ☐ Headache / Seizures
- ☐ Back Pain
- ☐ Kidney / Urine
- ☐ Insomnia (difficulty sleeping)
- ☐ Other: _____

## HOSPITAL ADMISSIONS / OPERATIONS

| Year | Illness or Operations |
|---|---|
| | |
| | |
| | |

## CURRENT MEDICATIONS

(Please include dosage)

_____

_____

_____

_____

## ALLERGIES

_____

_____

_____

_____

## IMMUNIZATIONS

(Please write approximate date)

Meningitis:_____Tetanus:_____ Pneumonia: _____ Influenza: _____ Gardasil:_____Shingles:_____

## FAMILY HISTORY

Please list any family history of medical issues

Mother: _____ Living: Y N

Father: _____ Living: Y N

Sisters: # ____ _____ Living: Y N

Brothers: # ____ _____ Living: Y N

## SOCIAL HISTORY

Do you wear seat belts? Y N

Do you exercise? Y N

Do you chew or smoke tobacco? Y N

IF YES:

How long have you used tobacco? _____

How much do you use daily? _____

IF NO:

Have you in your past? Y N

If you quit, how long ago? _____

Do you consume alcohol? Y N

How much per day _____ week _____ month _____

Are you sexually active? Y N

☐ Men ☐ Women ☐ Both

Are you happy with your life? Y N

Are you exposed to hazardous materials at work? Y N

What type of work do you currently do? _____

Do you travel out of the country? Y N

Are you a student? If yes, (circle one) FT or PT Y N

## WOMEN

Age you started your period? _____

Number of pregnancies? _____

Number of live births? _____

Start of last menstrual period? _____

Do you have sexual concerns? Y N

Do you use condoms? Y N

Do you use birth control? Y N

## MEN

Do you have sexual concerns? _____

Do you use condoms? _____

SILVER PINE MEDICAL GROUP


*Theodore L. Tangalos, MD*
*Steven G. Kotsonis, DO*
*Jennifer L. Hichme, MD*
*Steven J. Thibault, MD*
*Genevieve J. Crandall, MD*

*John J. Habicht, MD*
*Parag P. Patel, MD*
*Prameela N. Patel, MD*
*Tristan Guevara, DO*
*George T. Maristela, MD*

*Michael J. Raad, DO*
*Vasilios Gikas, DO*
*Naysha M. Varghese, MD*
*Antwan L. Hall, MD*
*Taylor K. McCarty, DO*


**Thank you for choosing Silver Pine Medical Group**

We look forward to seeing you on:

Date: _____ Time: _____

Doctor: _____ Office: _____

If you are a new patient, please arrive 30 minutes before your appointment time so you may complete new patient forms. For your convenience, we are enclosing the forms so you may complete prior to arrival. Please be sure to bring your picture ID and insurance card. Please also bring any medications and vitamin supplements you are taking.

If you have any questions, please feel free to call our office at (586) 726-4823.

We have 5 offices which can be found on the map below:

| Tilch Office | Sterling Office | Van Dyke Office | Romeo Plank Office | Chesterfield Office |
|---|---|---|---|---|
| Beaumont Macomb Medical Center<br>15959 Hall Rd, Suite 110<br>Macomb, MI 48044 | 43455 Schoenherr Rd<br>Suite 2<br>Sterling Heights, MI 48313 | 53950 Van Dyke Ave<br>Shelby Township, MI 48316 | 48801 Romeo Plank Rd<br>Suite 103<br>Macomb, MI 48044 | 31225 23 Mile Road<br>Chesterfield, MI 48047 |

SILVER PINE MEDICAL GROUP

# AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

Patient Name: (print) _____ Date of Birth: _____

Address: _____ Phone: _____

☐ I hereby authorize Silver Pine Medical Group to release information to:

**OR**

☐ I hereby authorize Silver Pine Medical Group to obtain information from:

| | |
|---|---|
| Name of Practice | Name of Practice |
| Address | Address |
| City, State, Zip | City, State, Zip |
| Phone / Fax | Phone / Fax |

## Type of Records Requested:

☐ Entire Medical Record (including the following if any)

Alcohol and drug abuse records protected under the regulations in 42 Code of Federal regulations, Part 2, psychiatric or psychological services records and social work records, including communication made by me to a social worker, psychiatrist, or psychologist. Information regarding communicable diseases and serious diseases and infections as defined by Michigan Department of Public Health Rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC.

☐ Other: _____

**Information to be released to or obtained by:**

| | | |
|---|---|---|
| ☐ Theodore Tangalos, MD | ☐ Steven Kotsonis, DO | ☐ Jennifer Hichme, MD |
| ☐ Steven Thibault, MD | ☐ Genevieve Crandall, MD | ☐ Parag Patel, MD |
| ☐ John Habicht, MD | ☐ Prameela Patel, MD | ☐ Tristan Guevara, DO |
| ☐ George Maristela, MD | ☐ Michael Raad, DO | ☐ Vasilios Gikas, DO |
| ☐ Naysha Varghese, MD | ☐ Antwan Hall, MD | ☐ Taylor McCarty, DO |

**Mail or Fax Records to:**

******* If over 25 pages, please mail records *******

43455 Schoenherr Road, Suite 2, Sterling Heights, MI 48313

Phone: (586) 726-4823 Fax: (586) 726-5977

Attention: Medical Records Department

This authorization is subject to written revocation at any time except to the extent that the individual / organization has already taken action on the authorization. If not previously revoked, this authorization will terminate six (6) months from the date of signature.

Signature of Patient or Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

**Name:** _____
**DOB:** _____
**Address:** _____

**Silver Pine Medical Group**

Please Complete & Bring back to your **Annual Wellness Visit**

List the names of your doctors and their specialty below:

| Name of Doctor: | Specialty: |
|---|---|
| | |
| | |
| | |
| | |
| | |

List all of your medications and their doses below:

| Name of Medicine: | Dose: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Please list any immunizations or preventative tests (labs, x-rays, etc.) you've had recently & where they were completed.

| Immunizations: | Location: |
|---|---|
| **Flu** | |
| **Pneumovax** | |
| **Prevnar** | |
| **Tetanus** | |
| | |
| **Tests:** | **Location:** |
| **Colonoscopy** | |
| **Mammogram** | |
| **Retinal Eye Exam** | |
| | |

If you have a living will or advanced directive, please **bring** it to your next appointment.

Feel free to discuss any questions or concerns with your provider

**Name:** _____
**DOB:** _____
**Address:** _____

**Silver Pine Medical Group**

Please check **yes** or **no** to the following questions. Some have follow-up questions, please answer accordingly. This information will be kept confidential.

| Questions: | Yes: | No: |
|---|---|---|
| 1. Are you worried about your memory? | | |
| 2. Have any of your close relatives had any health changes? | | |
| 3. Do you have trouble taking your medications the way you have been told? | | |
| 4. In the past year, have you ever had to go without health care because you did not have a way to get there? | | |
| 5. In the last year, have you needed to see a doctor, but could not because of cost? | | |
| 6. Do you need help controlling/managing your health problems? | | |
| 7. In the past month, have you felt more tired or fatigued? | | |
| 8. During the past month, have you felt bodily pain?<br>If yes, to what degree? (very mild, mild, moderate severe) _____ | | |
| 9. During the past month, have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, downhearted or blue? | | |
| 10. In the past month, have you had sexual problems? | | |
| | **Yes:** | **No:** |
| 11. Are you having difficulties driving your car?<br>If yes, how often? _____ | | |
| 12. Are you afraid you might get hurt in your home? | | |
| 13. Do you need information to help with hazards in your house that might hurt you? | | |
| | **Yes:** | **No:** |
| 14. Are you having difficulty exercising for 20 minutes at least 3 or more days a week? | | |
| 15. In the past month, did poor physical or mental health keep you from doing your usual activities, like work, spending time with family, or a hobby? | | |
| 16. Do you need help shopping for groceries or clothes? | | |
| 17. In the last year, did you ever eat less because there wasn't enough money for food? | | |
| 18. Do you need household items? Ex: Clothing, shoes, blankets, groceries, etc. | | |
| 19. Do you need help preparing your own meals? | | |
| 20. Do you need help eating? | | |
| 21. Do you need help bathing? | | |
| 22. Do you need help getting dressed? | | |
| 23. Do you need help with housework? | | |
| 24. Do you need help handling your money? | | |
| 25. Do you have problems using the telephone to make a call? | | |
| 26. Are you worried that in the next 2 months you may not have stable housing? | | |
| 27. In the last year, has your utility company shut off your services for not paying your bills? | | |
| 28. If any of the above questions are checked **YES**, would you like to receive assistance with any of these needs? | | |