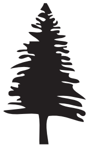


SILVER PINE MEDICAL GROUP

Date: ____________

PATIENT INFORMATION

Please Print

Birth Date ____ Social Security Number ___/___/___

Last ____ First ____ MI ____

Birth Sex: ☐ M ☐ F

Gender Identity: ☐ Transgender ☐ Prefer Not To Respond ☐ Non-Binary ☐ Other: ____

Address ____ City ____ State ____ Zip ____

Contact Numbers

Cell Phone ____
Work Phone ____
Home Phone ____

Primary Language

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

Marital Status

☐ Single ☐ Widowed
☐ Married ☐ Separated
☐ Divorced

Race

☐ White (caucasian) ☐ African American
☐ Asian ☐ More than one race
☐ Native Hawaiian ☐ Other Pacific Islander
☐ Native American / Alaska Native ☐ 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 ____ Sex ☐ M ☐ F Social Security Number ___/___/___

Address ____ City ____ State ____ Zip ____

RESPONSIBLE PARTY

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

Address ____ City ____ State ____ Zip ____

EMERGENCY CONTACT *(Please Print)*

Name ____ Phone # ____ Relationship ____

REFERRED BY

☐ Internet ☐ MPC ☐ Specialist Doctor
☐ PCP ☐ Beaumont Website ☐ Beaumont Reference System
☐ Family or Friend ☐ Neighborhood ☐ Established Patient
☐ Other ____

Please see reverse side

PATIENT HISTORY
Birth - 14 years

BIRTH HISTORY

Were there any complications during the pregnancy (Gestational diabetes, high blood pressure, infections, toxemia)?

____

Full term delivery? Y N How many weeks gestation? ____________________

Vaginal delivery or C - Section? ____________________

Did your child need any special care or medications after birth? ____________________

MEDICAL HISTORY

Does your child have any medical problems?

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Bad Vision
- ☐ Broken Bones
- ☐ Chicken Pox
- ☐ Constipation
- ☐ Diarrhea
- ☐ Depression
- ☐ Ear Infections
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Joint Pain
- ☐ Nervousness
- ☐ Frequent Respiratory Infection
- ☐ Seizures
- ☐ Weight Loss
- ☐ Other ____________

HOSPITAL ADMISSIONS AND OPERATIONS

Year	Illness or Operation

MEDICATIONS

____
____
____
____
____

ALLERGIES

____
____
____
____
____

IMMUNIZATIONS

(Please fill in the date of immunizations / child's age at that time)

DTaP	Polio	Hib	Hep A	Hep B	Meningiti	MMR	Rotovirus	Varicella
#1______	#1______	#1______	#1______	#1______	#1______	#1______	#1______	#1______
#2______	#2______	#2______	#2______	#2______	#2______	#2______	#2______	#2______
#3______	#3______	#3______	#3______	#3______			#3______	
#4______	#4______	#4______						
#5______								

SOCIAL HISTORY

How many people live in this child's household?______

Does anyone smoke in the household / daycare? Y N

Are firearms in the home? Y N

Do you have smoke detectors? Y N

Does your child ride in a car seat or use a seat belt? Y N

Does you child wear a bike helmet? Y N

Does your child exercise? Y N

Does your child have a special diet? Y N

Is your child in daycare? Y N

SILVER PINE MEDICAL GROUP

586.726.4823 Office
586.726.8365 Fax
www.silverpinedocs.com

Thank you for choosing Silver Pine Medical Group

We look forward to seeing you on:

Date: ____________________ Time: ____________________

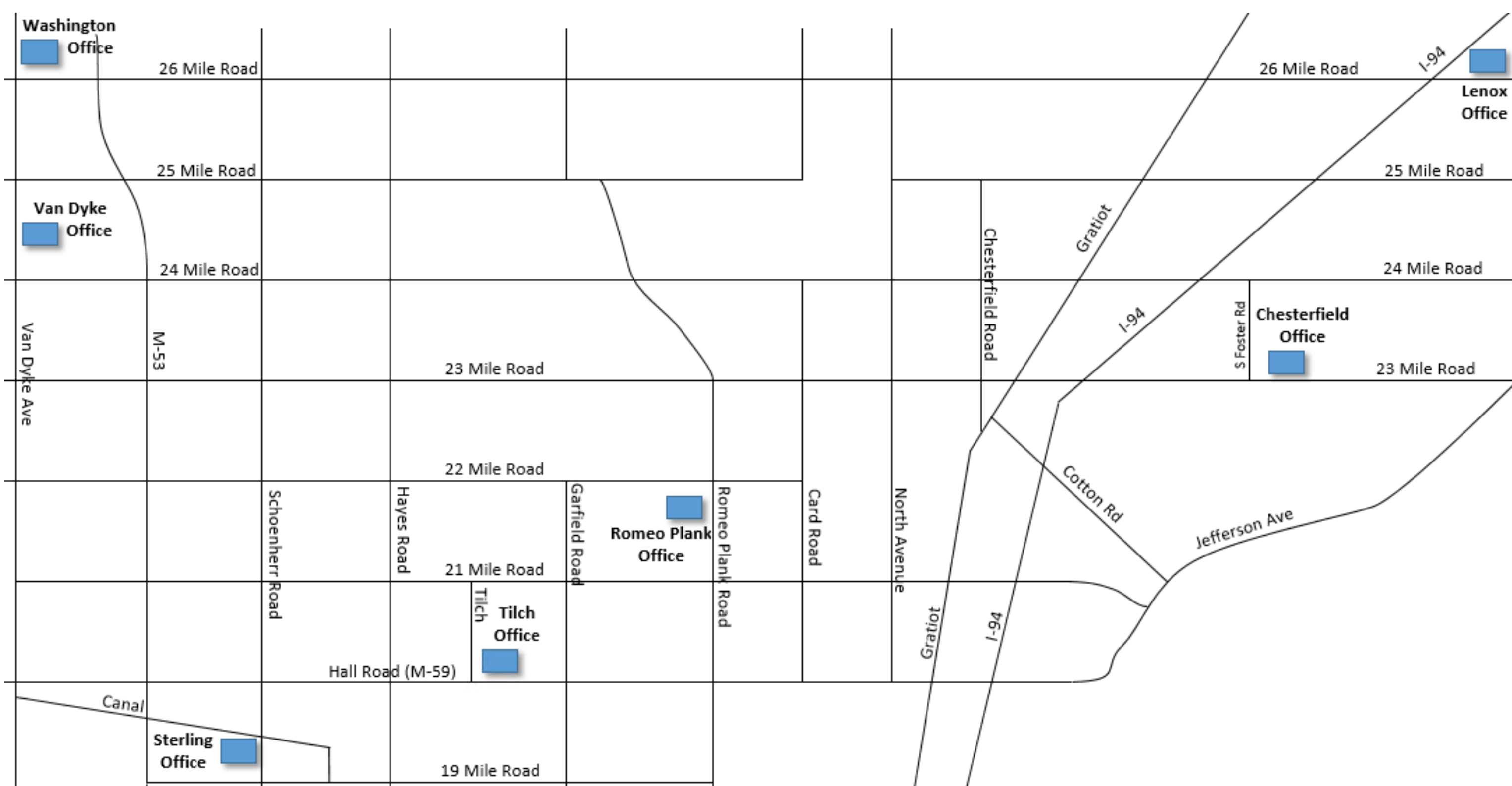
Doctor: ____________________ Office: ____________________

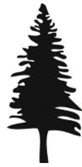
If you are a new patient, please arrive 30 minutes before your appointment time so you can complete new patient forms. For your convenience, we are enclosing the forms for you to complete prior to arrival. Please be sure to bring your picture ID and insurance card, along with any medications and vitamin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

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

We have 7 offices which can be found on the map below:

Tilch Office	Sterling Office	Van Dyke Office	Romeo Plank Office	Chesterfield Office	Lenox Office	Washington
Beaumont Macomb Medical Center 15959 Hall Rd, Suite 110 Macomb, MI 48044	43455 Schoenherr Rd Suite 2 Sterling Heights, MI 48313	53950 Van Dyke Shelby Twp, MI 48316	48801 Romeo Plank Suite 103 Macomb, MI 48044	31225 23 Mile Rd Chesterfield, MI 48047	36555 26 Mile Rd Suite 2500 Lenox, MI 48047	57850 Van Dyke, Suite 600 Washington, MI 48094





AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

1. **PATIENT INFORMATION**

PRINT Patient Name: ____ Birth Date: ___________________

Primary Care Provider: ____

Address: _______________________________ City: ____________________ State: ______ Zip: __________

Phone Number: (______) __________________ Email: ____

2. **SILVER PINE MAY RELEASE INFORMATION TO ☐ OR OBTAIN RECORDS FROM ☐** (Please choose one)

Organization or person: ____

Address: _______________________________ City: ____________________ State: ______ Zip: __________

Phone Number: (______) ______________________________ Fax: (______) ______________________________

Email: ____

DELIVERY METHOD FOR RECORDS: ☐ Mail CD ☐ Mail Flash Drive ☐ Fax (Under 25 pages)

3. **PURPOSE OF RELEASE:** ☐ Doctor ☐ Legal ☐ Insurance ☐ Medical Leave ☐ Personal / Other

4. **INFORMATION TO BE RELEASED FROM:** ______/______/______ **TO:** ______/______/______

☐ Medical Records ☐ Radiology reports: ____

☐ Immunizations ☐ Radiology images (on CD): ____________________________________

☐ Billing records ☐ FMLA documentation

☐ Other (provider, department, specialty): ____

5. **PATIENT AUTHORIZATION – I understand that:**

- Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental health and for patients ages 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.
- Generally, Silver Pine Medical Group and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations by Silver Pine Medical Group.
- I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.
- Once disclosed, health care information may be subject to re-disclosure by the recipient and may no longer be protected under health information privacy laws.

6. **This authorization expires one year from the date signed OR on the date or event indicated here:** _____/______/______

7. **SIGNATURE:** ____ **DATE:** ______/______/______

If personal representative*, print name and relationship: ____

*Documentation may be required to prove authority to sign on behalf of the patient.

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
Please allow up to 30 days for processing.

Note: Fees may apply to certain requests. Failure to follow instructions may result in processing delays.