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Clinton Women's Healthcare, PC

Obstetrics and Gynecology
clintonwomenshealthcare.com

Welcome to our Practice!!

We look forward to developing an on-going relationship with you. Our goal is to provide excellent Obstetrical and Gynecologic services for women of all ages, in a friendly and relaxed environment.

To expedite your first visit, please bring the following:

- The enclosed paperwork, completed in its entirety
- Your insurance card and driver's license (or valid photo ID)
- Any pertinent medical history or records

Introducing Phreesia!

A new registration tool for our patients, including the ability to register *before* your visit!

How It Works

We've invested in technology to better serve our patients. You'll now be able to check in from your tablet, mobile phone or computer ***before*** your appointment. Watch for a text message or email a few days before your appointment from "Phreesia", our new check-in platform. Simply click the link provided, no username or password is required, and you will be guided through a quick and easy step-by-step process. Once you've entered your information for the first time, you will not be required to do so again. At your future visits, you will only need to verify the information that you previously entered to ensure that it's current and to make any necessary edits.

Our online system allows you to register for your appointment and pay any co-pay or balance ahead of time and from the comfort of your own home, reducing your wait time at our office and allowing you to securely register when it's most convenient for you. Then just let the receptionist know you have arrived when you get to the office for your appointment and you're set!

We look forward to meeting you,

The doctors and staff at Clinton Women's Healthcare, P.C.

11051 Hall Road, Suite 110
Utica, Michigan 48317
Phone: 586-726-6556
Fax: 586-726-4917

48801 Romeo Plank, Suite 103A
Macomb, Michigan 48044
Phone: 586-726-6556
Fax: 586-726-4917

6483 Citation Drive, Suite A
Clarkston, Michigan 48346
Phone: 248-922-0856
Fax: 248-922-9368

Corewell Medical Staff Members

Patient – Provider Partnership
Specialist agreement

The health and wellness of our patients is a top concern of Clinton Women's Healthcare, PC. Providing the best possible specialty care to every patient is our primary goal. Your care will be coordinated with your Primary Care Physician (PCP). Below are some guidelines to make the best of this partnership.

As our patient, your responsibilities are to:

- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Follow through with recommended testing and contact our office if you are unable to get these tests completed.
- Enroll with the Patient Portal to retrieve your test results
- Participate and commit to the treatment plan that has been developed for you
- Be sure you understand the treatment plan, if not ask questions
- Tell us immediately if you are unable to follow your recommended treatment plan so we can modify it for you to receive the best results possible
- Be honest about your history, symptoms and other important information about your health
- Tell your healthcare team about any changes in your health and wellbeing
- Follow up with your Primary Care Provider for overall healthcare needs
- Be knowledgeable of your insurance plan and what services are covered

As your provider office, our responsibilities are to:

- Schedule your appointment as soon as possible
- Communicate regularly with your Primary Care Provider to make sure we coordinate your care
- Consider all your needs when we work with you to develop your treatment plan related to the reason for your referral
- Provide 24 hour access to medical care and same day appointments, whenever possible and provide instructions on how to meet your health care needs when the office is not open
- Provide you with information to help you learn how to self-manage your condition and assist you with establishing goals for this condition
- Provide you with clear directions about medicines and other treatment options
- Review all the medications you currently take and update regularly
- When necessary, direct and coordinate your care through referrals to appropriate community resources
- End every visit with clear instructions about your diagnosis, expectations treatment goals and future plans

Clinton Women's Healthcare, PC

Print Patient Name: ______________________ Date: __________

Patient Signature: ______________________ DOB: __________

Welcome!

Communication: It's important to know how to communicate privately regarding your healthcare needs and follow up. Please review the questions below to assist our staff in providing the best way to communicate with you:

Patient Name: ______________________________ DOB: ________________

Best way to reach you 8am-4pm?	☐ Primary Phone ☐ Alternate Phone ☐ Email
Messages:	☐ OK to leave message on answering machine/voice mail regarding my medical condition(s) or account matters. ☐ NOT OK to leave messages on answering machine/voice mail.
Family:	☐ OK to speak with a family member regarding my medical condition (s) or account matters. Name________________ Relationship________________________ ☐ NOT OK to speak with any family member.
Best way to confirm appointments:	☐ Primary Phone ☐ Alternate Phone
Waiting Room:	How would you like the staff to address you when calling you back to the exam room? ☐ First Name ☐ Last Name ☐ First and Last Name
Office Reminders:	☐ OK for our staff or automated attendant to contact me for appointments and office reminders. ☐ NOT OK to contact me for appointments or office reminders.
Special Instructions:	

Patient Secure Health Record Access: Clinton Women's Healthcare is committed to providing you with the latest updates regarding your healthcare needs. By providing your email address at registration, you will be invited to create your own **CWH Health Record Account** and communicate electronically by viewing lab results, requesting prescription refills, asking our staff medical questions, requesting appointments and requesting medical record forms and transfers.

Prescription Policy: With recent efforts to keep the cost of medications down, the Physicians primarily prescribe generic brand drugs, Prescription refill request can be done by calling the office prescription line or by signing in on *your CWH Record Account* to send requests. Refill requests require 48-72 hours for processing.

Pharmacy Information:

Local Pharmacy	Address/location	Phone	Fax
____________	____________	____________	____________
Mail in Pharmacy	**Address/location**	**Phone**	**Fax**
____________	____________	____________	____________

Race: (Please circle)

American Indian/Alaska Native Caucasian (white) Other Pacific Islander

Asian Native Hawaiian Refused to Report African American

More than one race Undefined

Ethnicity (Please circle)

Hispanic or Latino Refused to report

Non-Hispanic or Latino Undefined

CLINTON WOMEN'S HEALTHCARE
PATIENT QUESTIONNAIRE

Name ______________________________ Date ______________________________
Phone # ______________________________ Age________ Date of Birth ____________
Referred by ______________________________ Preferred Pronouns ______________

What is the reason for today's visit? ____
____
____

Menstrual History

Age of first period __________ Number of days of flow ____________
How many days between start of one period to the start of another? ______________
Amount of flow? (Circle One) Light Medium Heavy Are periods painful? (Circle One) Yes No
Age of menopause __________ Last Menstrual Period (date) ______________

Birth Control Method

____ Oral Contraceptives Brand ______________________
____ Nuva Ring ____ Patch ____ Condoms ____ Rhythm
____ Vasectomy ____ Tubal Ligation ____ None ____ Nexplanon
____ Intrauterine Device Brand __________________ Date of Insertion ______________

Gynecologic History

Do you have any history of the following problems? (Now or in the past) Check all that apply:

____ Abnormal Pap Smear
____ Breast Discharge
____ Breast Cancer
____ Chlamydia
____ Endometriosis
____ Fibrocystic Breast Change
____ Genital Herpes
____ Genital Warts
____ Gonorrhea
____ HIV/AIDS
____ Menopausal symptoms
____ Ovarian Cysts
____ Pelvic Inflammatory Disease
____ Premenstrual Syndrome
____ Sexual problems
____ Syphilis
____ Uterine Fibroids
____ Vaginal Infections

Obstetrical History

Please list all pregnancies including live births, stillbirths, miscarriages and ectopic pregnancies

Date	Hospital	Term/Preterm	Length of Labor	Type of Delivery

Past Medical History

____ ADD/ADHD
____ Anemia
____ Anxiety
____ Arthritis
____ Asthma
____ Bipolar Disorder
____ Bladder Infections
____ Blood Transfusion
____ Bloody/Tarry Stools
____ Cancer
____ Celiac Disease
____ Chicken Pox
____ Crohn's Disease
____ Depression
____ Diabetes
____ DVT/PE
____ GERD
____ Glaucoma
____ Hearing Problems
____ Heart Disease
____ High Blood Pressure
____ High Cholesterol
____ Kidney Stones
____ Liver Disease
____ Major Accident
____ Migraine Headaches
____ Mitral Valve Prolapse
____ Multiple Sclerosis
____ Myasthenia Gravis
____ Seizures
____ Skin Problems
____ Stroke
____ Systemic Lupus Erythematosus
____ Thyroid Disease
____ Ulcerative Colitis/Proctitis

PATIENT QUESTIONNAIRE

Past Surgical History

Year	Operation	Year	Operation

Medications and Dose (including Vitamins or Supplements)

____
____
____
____
____

Drug Allergies

____
____
____
____
____

Social History

Occupation ______________________________
Marital Status _____ Single _____ Married _____ Divorced _____Widow
Sexual Preference _____ Heterosexual _____ Homosexual _____ Bisexual _____ Other
Do you currently Exercise? _____ Yes _____ No Type of Exercise? ____________________
Do you currently smoke cigarettes? _____ Yes _____ No If Yes, # of cigarettes per day? ________
Do you Vape? _____ Yes _____ No Former cigarette smoker? _____ Yes _____ No
Do you drink Alcohol? _____ Yes _____ No Number of drinks per week? ____________________
Do you use drugs? _____ Yes _____ No Type of drugs used ____________ Frequency ____________

Family History (please indicate family member)

__________ Heart Disease
__________ Hypertension
__________ High Cholesterol
__________ Diabetes
__________ Birth Defects
__________ Osteoporosis
__________ Breast Cancer
__________ Ovarian Cancer
__________ Uterine Cancer
__________ Colon Cancer
__________ Cancer (other)

Screening Tests

Date of Last Pap Smear ____________________ _____ Normal _____ Abnormal
If abnormal, indicate date and treatment ______________________________________
Date of Last Mammogram ____________________ Normal? Yes ____ No____ Abnormal? Yes ____ No____
Date of last Cologuard ____________________ Date of last Colonoscopy ____________________

Other Information

Please list any other pertinent medical information or questions you would like to address:

____
____
____
____
____
____