Today's Date: _____ **PATIENT INFORMATION** Michael G. Taylor, M.D.
PLEASE PRINT

Name: _____ Birth Date: _____ Age: _____
Last First M.I. Male _____ Female _____

Address: _____ Marital Status: M S D W

City: _____ State: _____ Zip Code: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone:(___)_____

E-Mail (for access to Patient Portal only): _____

ER # other than home: _____ _____ (__) _____
Name **Relationship** **Phone Number**

Referring Doctor: _____ Family Doctor: _____

Patient's Soc. Sec. Number: _____ Health Insurance Carrier: _____

Policy Holder's Soc. Sec. #: _____ Policy Holder's Birth Date: _____

Patient's Employer: _____ Phone # (___) _____
Company Name / Address / **Please Circle: Full Time or Part Time**

Patient's Spouse's Employer: _____ Phone # (___) _____
Company Name / Address / **Please Circle: Full Time or Part Time**

If Retired, from where? Self / Spouse: _____
Company Name / Date of Retirement

Is Injury Work Related: YES / NO *(circle)* If yes, was incident reported to employer? _____

Date of Injury: _____ Name of Workers Compensation Carrier: _____

Is injury a result of an Auto Accident: YES / NO *(circle)* Date of Accident: _____

List Previous Surgeries and Dates: _____ _____ _____

_____ _____ _____ _____

List Medications with Dose and Quantity (Including **Aspirin, Vitamin and/or Herbal Supplements**):

_____ _____ _____ _____

_____ _____ _____ _____

Pharmacy Name/Location: _____ Pharmacy #: _____

ALLERGIES TO MEDICATIONS? YES / NO *(circle)* **If yes, please list and explain reaction:**

_____ _____ _____ _____ _____

ARE YOU ALLERGIC TO LATEX? _____ **If yes, please explain reaction:** _____

Patient's Name: _____ Michael G. Taylor, M.D.

CHIEF COMPLAINT: _____ _____
(Reason you are seeing the doctor today) **(How long have you had symptoms)**

Social/Medical History:

Ethnicity: _____ Race: _____ Preferred Language: _____
Please initial if you decline to provide the above information: _____

Do you smoke? _____ Cigarettes (Qty) _____ Cigars (Qty) _____ Marijuana (Qty) _____
Do you drink alcohol (Beer, wine, liquor, other)? _____ How much? _____ How often? _____

Personal history of Cancer: YES / NO Type _____ When/Age _____
Personal history of Diabetes: YES / NO Insulin Dependent / Medication / Diet _____

Please check all that apply:

___ Hypertension	___ Heart Condition	___ Thyroid Disease
___ Kidney Disease/Stones	___ Emphysema	___ Ulcers
___ Eye Diseases	___ Menopause	___ Asthma
___ Stroke	___ HIV	___ Arthritis

If checked, please explain: _____

Please circle yes or no to ALL of the following conditions which you may have experienced:

Constitutional			***Endocrine***			***Ear/Nose/Throat***			***Neurological***		
Recent weight change + / - # of pounds	Y	N	Excessive thirst	Y	N	Hearing loss/ringing	Y	N	Frequent headaches	Y	N
Night sweats/fever	Y	N	Excessive urination	Y	N	Sinus problems	Y	N	Paralysis/tremors	Y	N
Fatigue	Y	N	Thyroid disease	Y	N	Nose bleeds	Y	N	Convulsions/seizures	Y	N
Cardiovascular			Hormone problems	Y	N	Throat – Sore/Voice	Y	N	Numbness/tingling	Y	N
Chest pain	Y	N	***Genitourinary***			***Respiratory***			***Skin/Breast***		
Palpitations	Y	N	Blood in urine	Y	N	Shortness of breath	Y	N	Change in hair/nails	Y	N
Heart trouble	Y	N	Sexual problems	Y	N	Cough	Y	N	Rashes or itching	Y	N
Swelling hands/feet	Y	N	Testicle pain	Y	N	Wheezing/Asthma	Y	N	Breast lump	Y	N
Musculoskeletal			Menstrual problems	Y	N	Coughing up blood	Y	N	Breast pain/discharge	Y	N
Muscle pain/cramps	Y	N	***Psychiatric***			***Hematologic/Lymph***			***Gastrointestinal***		
Joint swelling/stiffness	Y	N	Insomnia	Y	N	Bruise easily	Y	N	Nausea/vomiting	Y	N
Joint pain	Y	N	Confusion/memory	Y	N	Slow to heal	Y	N	Abdominal pain	Y	N
Eyes			***Allergies***			Enlarged glands	Y	N	Rectal bleeding	Y	N
Eye glasses/contacts	Y	N	Food Allergies	Y	N				Bowel problems	Y	N
Vision problems	Y	N	Other	Y	N						

Further explanation of any of the above symptoms: _____

_____

Patient Statement: ***To the best of my knowledge, the above information is accurate and complete.***

Patient's Signature: _____ **Date:** _____

Doctor Statement: ***I have reviewed the questionnaire with the patient.***

Doctor's Signature: _____ **Date:** _____

Michael G. Taylor, M.D., F.A.C.S.
General Surgery

Authorization to disclose Private Healthcare Information (PHI) is defined in Our Privacy Notice. (Under separate cover)

INSURANCE ASSIGNMENT & FINANCIAL RESPONSIBILITY

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO DR. MICHAEL G. TAYLOR, FOR ANY SERVICES RENDERED TO ME. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAYS OR DEDUCTIBLES THAT MY INSURANCE COMPANY DOES NOT COVER.

SECOND OPINIONS

SOME INSURANCE COMPANIES REQUIRE A SECOND OPINION FOR CERTAIN SURGERIES. THE PATIENT IS RESPONSIBLE FOR OBTAINING THE SECOND OPINION. YOU SHOULD DO SO BY CONTACTING YOUR INSURANCE COMPANY. THEY WILL LET YOU KNOW IF ONE IS REQUIRED PRIOR TO YOUR SURGERY. PROCEDURES MOST LIKELY TO BE AFFECTED ARE; HERNIAS, MASTECTOMIES, SOME BREAST BIOPSIES & THYROID SURGERY. THIS DOES NOT APPLY TO PATIENT'S WITH MEDICARE OR MOST HMO'S. AGAIN, WE STRESS THAT YOU CONTACT YOUR INSURANCE COMPANY FOR THIS INFORMATION. THE OFFICE WILL OBTAIN ANY AUTHORIZATIONS OR PRECERTS REQUIRED PRIOR TO YOUR SURGERY.

SIGNATURE: _____ _____
Patient Date

SIGNATURE: _____ _____
Guardian/Relationship Date

Patient Information Acknowledgment and Consent

I hereby acknowledge that I am aware that my physician, Dr. Michael G. Taylor, has the capability to access medical information regarding me that is generated by hospital facilities via the hospital remote access system; this includes past as well as current and future episodes of care. I realize that this information may contain:

A. Information about communicable diseases and serious communicable diseases and infections, as defined by the Michigan Department of Public Health rules (which include venereal disease "VD", tuberculosis "TB", hepatitis, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS" and AIDS-related complex "ARC").

B. Alcohol and drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2; and

C. Mental health treatment records, psychiatric services, psychological services, and social services information including communications made by me to a psychiatrist, social worker, or psychologist.

I hereby give Dr. Michael G. Taylor and his office staff authorization to access all medical information regarding myself through hospital remote access systems for the purpose of continuing patient care. This authorization includes all information – past, present and future.

This authorization relates only to the access of information for my continuing care; it does not authorize re-release of information to any third party.

This authorization is effective on the date of the signature and may be revoked by me, in writing at any time and unless so revoked, it will expire at the time that I am no longer being actively treated by this physician.

_____	_____	_____
Patient Signature	Patient (Printed Name)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian (Printed Name)	Date
_____	_____	_____
Witness Signature	Witness (Printed Name)	Date

Name: _____

FAMILY HISTORY

Date: _____

PLEASE CHECK ALL THAT APPLY

	Mother	Father	Sister	Brother	Son	Daughter	Grandma	Grandpa	Aunt	Uncle
Cancer (Unknown Type)										
Lung Cancer										
Ovarian Cancer										
Breast Cancer										
Colon Cancer										
Prostate Cancer										
Bladder Cancer										
Stroke										
Congestive Heart Failure										
Coronary Artery Disease										
Hypertension										
Diabetes										
Asthma										
Hypercholesterolemia										
Depression										
Epilepsy										
Cataract										
Anemia										
Obesity										
Suicide										
Leukemia										
Osteoporosis										
Hemiplegia										

Michael G. Taylor, M.D., F.A.C.S.

April 1, 2014

Dr. Michael G. Taylor, M.D.
General & Laparoscopic Surgery

Patient Release Form

Date: _____
Effective (Today's Date)

Date: _____
Expires (Three Years)

_____. I am currently a
Patient's name (printed)

patient of Dr. Michael G. Taylor (General Surgeon). I, being the patient, am requesting that my medical information can be copied for (in my absence) or discussed with the recipient if I am not available. This would include limited information only.

_____/_____
#1 Recipient name printed Relationship to the Patient

_____/_____
#2 Recipient name printed Relationship to the Patient

_____
Patient signature Date

_____
Witness signature Date

I DO NOT wish to have any of my medical information released.

_____
Signature Date

Please sign this form once you have reviewed the Privacy Policy, Notice of a Breach, and the Patient-Provider Agreement found under Privacy Policies.

ACKNOWLEDGEMENT OF RECEIPT AND NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form for Dr. Michael G. Taylor.

_____ _____

Patient Signature *Witness Signature*

_____ _____

Date *Date*

Documentation of Failure to Obtain Signed Acknowledgment

On _____, 200__, Dr. Michael G. Taylor presented this Acknowledgment of Receipt and Notice of Privacy Practices Form to

_____

Patient name

And the Patient refused to provide a signature when requested.

Witness: _____

** PLEASE COMPLETE THIS FORM IF YOU HAVE MEDICARE **

Medicare Secondary Payer (MSP) Questionnaire

Patient Name: _____ **Medicare HIC #:** _____ **DOS:** _____

1) **Working Aged:**

Are you or your spouse currently employed?	Yes ___	No ___
Are you or your spouse currently self employed?	Yes ___	No ___
Number of work hours per week? _____		
Do you currently have health insurance coverage other than Medicare?	Yes ___	No ___
Does your current employer have more than 20 employees?	Yes ___	No ___

2) **Disability**

Are you entitled to Medicare based on a disability from which your employer has more that 100 employees and provides you a Health Insurance plan?	Yes ___	No ___

3) **Auto, Liability, Workers Compensation:**

Are the services being provided the result of an auto accident which is covered by a liability insurance plan?	Yes ___	No ___

4) **End Stage Renal Disease (ESRD):**

Is the patient entitled solely on the basis of ESRD only? If **"yes"** then is Medicare secondary for the first 18 months?	Yes ___	No ___

5) **Misc:**

Is there any other Health Insurance Plan that may cover these services? (i.e. Black Lung, VA, etc.)	Yes ___	No ___

6) **Retirement Information:**

Are you or your spouse retired? Your retirement date: _____ Spouse's retirement date: _____	Yes ___	No ___

If you answered **YES** to questions 1 – 5 **(not #6)** above, Medicare is the secondary payor. Please provide the additional health insurance information requested below.

Plan Name: _____ Contract Number: _____

Group Number: _____ Other: _____