STEPHENIE LUCAS, M.D.
ENDOCRINOLOGY, DIABETES AND
WEIGHT MANAGEMENT

Dr. Logan Oney and Stephenie Lucas
22631 Greater Mack Ave Suite 100
SCS, MI 48080
586-771-0100 Fax 586-771-0400

Dear Patient:

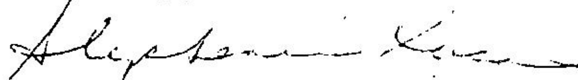
Thank you for making an appointment. In order to make your initial visit the most productive, please follow the instruction:

1. Carefully complete the enclosed history form. This is very important.
2. Bring all current medications with you.
3. Bring any pertinent past medical records.
4. If your appointment is before 11:00 A.M., do not eat past midnight the evening before.

I look forward to seeing you.

Appointment time: ________A.M. ________P.M.
Mon. ________ Tues. ________ Wed.________ Thurs.________
Fri. ________
Month: ____________________ Day: ____________________

Sincerely,



Stephenie M. Lucas, M.D.

SML/JS

PATIENT INFORMATION SHEET

PLEASE COMPLETE ALL THE INFORMATION REQUESTED TO INSURE PROPER HANDLING OF YOUR INSURANCE BILLING FOR YOUR OFFICE VISITS.

DR.____________________
CHART #__________________
DATE____________________

PATIENT LAST NAME (Please Print)	FIRST	INITIAL	MAIDEN NAME

SOCIAL SECURITY NUMBER	SEX M F	BIRTHDATE
HOME PHONE NUMBER AREA CODE ( )	MARITAL STATUS M S D W	REFERRED BY

STREET ADDRESS	APT #	CITY-STATE	ZIP CODE

EMPLOYER NAME	EMPLOYER ADDRESS	WORK PHONE NUMBER ( )
SPOUSES NAME		SPOUSES BIRTHDATE
SPOUSES EMPLOYER	EMPLOYER ADDRESS	WORK PHONE NUMBER ( )
PERSON TO NOTIFY FOR EMERGENCY (NOT LIVING WITH PATIENT)		RELATIONSHIP TO PATIENT

ADDRESS	CITY-STATE	ZIP	PHONE

INSURANCE INFORMATION - PLEASE FILL OUT ALL SECTIONS THAT APPLY.

MEDICARE	MEDICARE NUMBER	EFFECTIVE DATE	
MEDICAID	MEDICAID ID NUMBER	MEDICAID CASE NUMBER	
BLUE CROSS. BLUE CARE, NETWORK, BLUE PREFERRED, FEP, ETC.	POLICY HOLDERS NAME	RELATIONSHIP TO POLICY HOLDER	POLICY HOLDERS BIRTHDATE
	GROUP NUMBER	SERVICE CODE	
	CONTRACT NUMBER	EMPLOYER NAME	
OTHER INSURANCE	INSURANCE NAME	INSURANCE PHONE NUMBER	
	INSURANCE ADDRESS	CITY - STATE - ZIP CODE	
	POLICY HOLDERS NAME	RELATIONSHIP TO POLICY HOLDER	POLICY HOLDERS BIRTHDATE
	SOCIAL SECURITY NUMBER	GROUP OR POLICY NUMBER	

Please Read and Sign Important Information On Back

We welcome to our practice!

We ask that you read and sign this because it concerns all of us. Due to the many changes in insurance policies it is no longer an easy task to interpret each individual policy. Although we try to stay aware of changes, insurance companies often notify of us of these changes after they have taken effect. Therefore, we urge you, as the patient, to please check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in your, the patient, being responsible for the costs incurred. You must know if your employer or insurance company has contracted with a specific family for lab, x-ray, and other special procedure services. If the service is performed by the wrong facility, you are potentially responsible for the bill.

In addition, if you are a member of a Health Maintenance Organization (HMO), Point of Service (POS), or other Managed Care insurance plan there are specific rules that you must follow in order for them to pay for your care;

* Your insurance will not pay if you go to any specialist or testing facility unless your primary care physician sees you first and formally refers you to a specialist in the insurance network system. Most insurance companies will not approve referrals retroactively, so be sure that your visit or procedure has been authorized by your insurance company prior to service.

* Your insurance will not pay for emergency room care unless you follow their emergency guidelines and your emergency room treatment meets their emergency criteria. The only exceptions are:
  - Life threatening situations.
  - Those emergency situations which occur when you are away from the Detroit area.

Please learn about your coverage. It could save you time and money in the long run.

Thank you,

Stephenie M. Lucas, M.D.
Logan A. Oney, M.D.

I have read and understand these basic insurance policies and will notify the practice of any changes in my insurance benefits.

____

Signature of patient or guardian Date

Assignment of Insurance Benefits

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I authorize release of all medical information required to process my claims and is pertinent to my medicare care. My signature on this document authorizes direct payment to the physicians. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I understand that I am financially responsible for charges not covered by this assignment.

____

Signature of patient or guardian Date

Name:________________________________Date:_________Primary Doctor:_________________

Please list the reason for todays visit:

____

Please list the medications that you take including the dose and how often you take the medication

Name of Medication	Dosage (in Mg or units)	How often do you take this med

Please list any allergies :____

Medical History: Please check yes for any that apply

Sinus problems	yes☐	Anemia	Yes☐	Arthritis	Yes☐	Pituitary problem	Yes☐
Prostate enlarged	yes☐	Cancer	yes☐	Kidney disease	Yes☐	Poor Circulation	Yes☐
Colon Polyps	yes☐	COPD /Asthma	yes☐	Heart disease	yes☐	Calcium problem	Yes☐
Stroke	yes☐	Depression	yes☐	Diabetes mellitus	yes☐	Adrenal Problem	Yes☐
Erectile dysfunction	yes☐	GERD	yes☐	High Cholesterol	yes☐	Menstrual problem	Yes☐
High blood pressure	yes☐	Thyroid problem	yes☐	Osteoporosis	yes☐	History of blood clots	Yes☐

Additional health problems____

Do you wear seat belts, use smoke detectors wear safety equipment like helmets and do you store any fireams appropriately yes☐ no☐ Do you have an advanced directive ? yes☐ no☐

SURGICAL HX: please check yes for any that apply

Angioplasty/Stent	yes☐	Appendix surgery	Yes☐	Radiation treatment	yes☐
Weight loss surgery	yes☐	Heart surgery	yes☐	Cataract Removal	yes☐
Gall bladder surgery	yes☐	Colon surgery	yes☐	Cancer surgery	yes☐
Pituitary surgery	yes☐	Hysterectomy	yes☐	Back surgery	yes☐
Lumpectomy	yes☐	Mastectomy	yes☐	Hip surgery	yes☐
Knee surgery	yes☐	Splenectomy	yes☐	tonsillectomy	yes☐
Tubal Ligation	yes☐	Valve Replaced	yes☐	Vasectomy	yes☐

OTHER SUGRICAL HISTORY: ____

Substance HX:

Tobacco Use: ☐ yes ☐ Never ☐ Quit ☐ Smoker in house ☐ How many years since you quit:_________

Present Packs/Day 0.25 ☐ 0.5 ☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 3.0 ☐ Years: ☐ 3 ☐ 5 ☐ 10☐ >20☐ other: ___________

Smokeless tobacco: Yes ☐ Never ☐

Alcohol Use: yes☐ no☐

Average number per week: Glass of wine ___________ Oz/Week ___________________

Cans of Beer ___________ Shots of liquor ___________ Drinks containing 5oz ___________

Drug Use: yes☐ no☐ Per Week 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 10☐ 15 ☐ other: ___________________

Health Maintenance: Please give approximate date of your last

Mammogram ___________Pap/Pelvic Exam ___________ Prostate Exam___________

Colonoscopy/Sigmoidoscopy ___________ Stool Occult Cards ___________ Bone Density___________

Physical exam ___________Eye Exam _________ Stress Test_________Chest Xray___________

Date of last: Tetanus Shot__________ Flu Shot___________ Pneumonia shot __________TB Skin Test_________

Exercise: yes☐ no☐

Family HX: initial family who have had the following (M=mother F= Father S=Sibling G=Grandparent)

Heart disease __________ High blood pressure __________Asthma __________ High Cholesterol_____ Stroke __________ Seizures __________ Diabetes____________________Thyroid problems__________Clotting disorder___

Breast CA ___________ Colon CA ___________ Prostate Ca __________Ovarian CA __________

Sexually Active: Yes☐ No☐ Not currently ☐ Sex of Partner Male ☐ Female ☐

Birth Control/STD Protection☐None ☐Condom ☐ Pill ☐ Diaphram ☐ IUD ☐ Surgical Do you want an HIV test yes☐ no☐

Marital Status: Single Yes☐ Married Yes ☐ Live Alone Yes☐ **Live with:** Partner☐ Children☐ Parent ☐ Grandparent ☐

Occupation ______________________________Retired ☐

Schooling completed: ☐ 8th grade ☐ High School ☐ College ☐ Grad School

Please indicate if you are experiencing any of the following:	Circle and describe below
Fever, Chills, Nightsweats, Extreme Weight Change, Change in Appetite	
Skin Rashes, Growing Moles, Non-healing skin lesions	
Bone Pain, Joint Pain, Joint Swelling, Muscle Aches, history of fracture	
Headaches, Dizziness, blackouts, seizures	
Change in Vision, Eye Pain, Double Vision, Eye discharge	
Ear Pain, Discharge, Decreased Hearing, Ringing in ear	
Nose: Bleeding, Discharge, Sinus Pain	
Mouth & Throat: Sores, Teeth, Bleeding gums	
Nodules in neck, enlarged lymph nodes, pain or tenderness in neck, history thyroid cancer	
Breast discharge or masses, Breast pain , history breast cancer	
Cough, Wheezing, shortness of breath, Snoring, Daytime drowsiness	
SOB, swelling in the legs, Chest Discomfort, Palpitations, blacked out	
Trouble Swallowing, Heartburn, , Nausea, Vomiting, abdominal Pain, Constipation, Diarrhea, black stools, Red Blood in Stools, Hemorrhoids, loss of bowel control , Jaundice	
Burning, Pain with urination , kidney stones Blood in urine , increased urinary Frequency, Hesitancy, Dribbling, Nighttime urination, Incomplete Emptying of bladder, Incontinence, Testicular Masses, Sexual Function problems	
Number of pregnancies____, Number of children___________ last menstrual period_________ Irregular Bleeding, menstrual cramps, Hot Flashes, Postmenopausal Bleeding	
Please describe other concerns	

If you have Diabetes please complete the following

Do you have ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐Not Sure

Year that your Diabetes was diagnosed: ____________ Your age when diagnosed_________

Diabetes diagnosis made by ☐Diabetic ketoacidosis ☐ Blood test ☐ your symptoms

Date of **last eye exam**_________________________Name of **Eye Doctor**________________

Family Members with diabetes (check all that apply)

☐None ☐Mother ☐Father ☐Siblings ☐Children ☐Grandparent

Number of hospitalizations for diabetes in the past 5 years ☐ None ☐<-5 ☐ >5

Do you have ☐ Diabetic eye disease☐ Kidney disease ☐neuropathy/nerve damage☐numbness hands or feet

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes ☐ No ☐

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes☐ No☐

Exercise frequency ☐ None ☐<90 minutes a week ☐>90 minutes a week

Do you stick to your diet ☐<25% of the time ☐25-50% ☐50-75% ☐>75% ☐do not understand diet

Please check all that you do ☐ Check your feet most days ☐ check your sugar before driving ☐have a glucagon emergency kit ☐ know how to carb count ☐carry a sugar source ☐have attended a diabetes education class in the past year ☐wear diabetic ID

Please indicate your personal goals for your diabetes: ☐ Take less meds☐ understand diabetes☐improve diabetes control☐ avoid diabetic complications☐ other please list______________________________

Average number of low sugars you experience in a week: ☐ None ☐1-5 ☐ >5 Time of day occurs______

Average number of high sugars you experience in a week: ☐ None ☐1-5 ☐ >5 Time of day occurs______

Time	Average sugar	Med taken	Dose of med in mg or units
Before breakfast			
Before lunch			
Before dinner			
Bedtime			

Center For Preventive Medicine
22631 Greater Mack Ave Ste. 100
S.C.S. MI. 48080

Notice of privacy Practices
Patient Acknowledgement

Patient Name:________________________________

Date of Birth: ____________________

I have been given the opportunity to review this practice's "Notice of Privacy Practices". The Notice provides information about the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respects to my information.

I understand that this practice possesses the right to change the terms of its Notice of Privacy Practices, and to make changes regarding protected health information resident at, or controlled by, this practice. I understand that I can obtain this practice's current Notice of Privacy upon request.

Signature: ___________________________

Date: _____________________________

Relationship to patient (if signed by a personal representative of the patient):

____

OUR MEMO OF UNDERSTANDING

Thank you for choosing our medical practice as your home base for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide you with complete, continuing and personal medical care.

In order for this goal to be possible, it is important that we each commit to fulfilling certain responsibilities.

PHYSICIAN RESPONSIBILITIES

- Listen to you as to your health care matters, and encourage a culture of open, full and frank communication.
- Provide counsel and information regarding the different treatment plans for chronic conditions or prevention programs.
- When possible, provide convenient options including electronic access for non-urgent communications for scheduling office visits and follow up visits, and for obtaining test results and referrals.
- Provide flexible and expanded office hours, schedule appointments within a reasonable time, and see Patient as closely as reasonably possible to scheduled appointment time.
- Provide telephone availability to Physician for urgent communications 24 hours per day, 7 days per week.
- As technology develops, provide convenient options for non-urgent communications between Patient and Physician including post-hospital support, follow up visits and consultations.
- Use a team approach to health care by providing access to other clinicians and health care institutions when and where appropriate.
- Coordinate and integrate care provided by my practice team and other clinicians and health care institutions effectively so as to avoid duplication, delay and error.
- Communicate test and treatment results promptly and correctly.
- Provide information, recommendations and advice regarding preventative care, maintaining wellness, self-management direction and counseling.
- Send reminders of the need for follow up care and preventative care.
- Maintain clinical information in a format that allows for ready search, retrieval and information transfer while protecting privacy and confidentiality, including participating in the development and maintenance of standardized electronic health records and patient registries.
- Coach the medical home base staff in the responsibilities described above.

PATIENT/PARENT/CAREGIVER/LEGAL GUARDIAN RESPONSIBILITIES

- Communicate openly, fully, frankly and proactively with Physician and Physician's staff.
- Be an active participant in the development with Physician of action plans and treatment plans for Patient's acute or chronic condition, and follow agreed-upon treatment plans.
- Provide Physician with feedback regarding Patient's treatment plan.
- Appear on time for appointments, procedures and other medical tests at Physician's office, and timely submit materials, samples and information as requested by Physician.
- Schedule and attend follow up appointments at intervals suggested by Physician.
- Involve yourself in Physician's and other health care professionals' recommendations with respect to maintenance or improvement of Patient's health and wellness.
- Participate in action planning and goal setting with respect to maintenance or improvement of Patient's health and wellness.
- Participate in developing and maintaining a comprehensive health record by authorizing delivery and circulation of clinical information to and from clinicians and health care institutions.

Please take the time to carefully read this Memo of Understanding. Kindly sign your name in the appropriate place below.

Physician Signature ______________________ **Patient /Caregiver** ______________________

Today's Date: ______________________