Michele Thomas, M.D.
Patrice Harold, M.D.

29255 Northwestern Hwy
Suite 301
Southfield, MI 48034
Phone 248-354-2201
Fax 248-354-2220

Patient Name
Contact Address
City, State Zip

Your appointment is for: Date at Start Time

With: Provider Name

Dear Ms. Patient Name,

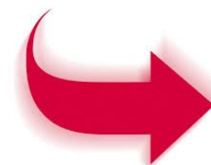
Thank you for choosing Southfield OB/GYN Associates to participate in your health care needs.

1. Please arrive 15 minutes prior to your appointment to allow us to verify your insurance coverage.
2. You will need to bring your insurance card, driver's license or state ID, and the completed forms enclosed.
3. Payment is expected at the time of service for any co-pays, deductibles, and non-covered services.
4. If you are more than 15 minutes late for your appointment, it will be necessary to reschedule our appointment. Appointments should be canceled 24 hours in advance.
5. The office is located on Northwestern Highway between 12 Mile and Inkster Road, on the West side of Northwestern Highway.
6. If you are coming in for fibroids, endometriosis, ovarian cyst, abnormal pap, second opinion, or transferring prenatal care to us please make sure you bring your recent labs and radiology results or have them faxed to our office.
7. In order to keep our patients and staff safe, MASK must be worn during your entire visit to our office.
8. Family members and other guest will not be able to attend your visit, including the waiting/reception area.

If you have any questions or concerns prior to your visit, please contact the office.

Sincerely,

The Staff of Southfield Ob/GYN Associates



TURN OVER

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Name____
(First) (Last) (Middle Initial)

Date of Birth:________________ SSN:___________________

Marital Status:
☐ Married ☐ Single ☐ Divorced ☐ Widow

Patient Race:
☐ Black or African American ☐ White
☐ American Indian or Alaska NA ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Other Race
☐ Hispanic or Latino ___________________

Primary Language Spoken:
☐ English ☐ Spanish ☐ Other: Specify_______________

Address:____
City/State/Zip: ______________________________________
Home Phone ( )_____________________________________
Cell Phone ( )_____________________________________
Email Address:_______________________________________

Preferred Contact phone number is:
☐ Home ☐ Mobile ☐ Work

Emergency Contact Name :__________________________
Emergency Phone( ) ____________________________
Emergency Cell ( )_______________________________
Emergency Contact Relationship: _____________________

Patient's Employer:________________________________
Employer Phone( )______________ Fax( )___________

Primary Insurance Company: ___________________________
Primary Guarantor Name:_____________________________
Primary Guarantor Relationship:_________________________
Primary Guarantor Date of Birth:________________________
Primary Guarantor Employer: ___________________________
Primary Guarantor ID#________________________________

Secondary Insurance Company: _________________________
Secondary Guarantor Name: ___________________________
Secondary Guarantor Relationship:______________________
Secondary Guarantor Date of Birth:_____________________
Secondary Guarantor Employer:________________________

Tertiary Insurance Company:___________________________
Tertiary Guarantor Name:______________________________
Tertiary Guarantor Date of Birth:________________________
Tertiary Guarantor Employer:___________________________

Pharmacy Name:__________________________________
Pharmacy Phone:___________________________________
Pharmacy Fax:_____________________________________
Pharmacy Address:__________________________________
City/State/Zip:_____________________________________

Primary Care Physician: ____________________________
Address:____
City/State/Zip:_____________________________________
Phone ( )____
Fax ( )____

Please Check yes or no:
Do you have a legal written document *which allows a specific person to make medical decisions for you; if you are not able to?* (Advance Directives)
☐ Yes or ☐ No

I ____, consent to investigation and treatment upon each visit, including a medication history for medication reconciliation/prescription(s). I hereby authorize Dr. Patrice Harold and Dr. Michele Thomas to bill my insurance carrier for services rendered. In the event that my insurance carrier does not pay, I agree that I am responsible for payment. I understand failure of payment may be sent to a collections company.

Patient Signature____Date__________________

Guardian Signature____Date__________________

Date: ______________

Patient Name: ______________________________Patient Date of Birth:__________________________

Have you ever had a Mammogram ☐Yes☐No If yes when? ______________

Date of last PAP SMEAR? ______________First day of last Menstrual Period?_____________________

What age was your first period? _______ How heavy is your flow? ________________________________

How many days from the beginning of one period to the next? __________________________________

Are you sexually active? ☐Yes☐No Do you have pain with intercourse? ☐Yes ☐No

What is your present method of birth control? ____

For patients ages 12-26, have you received the Gardasil (Human Papilloma Virus) Immunization? Yes or No (see below)

☐ **If No**, have you ever received information on the Gardasil Immunization (Human Papilloma Virus)? **Yes or No (circle one)**

☐ **If Yes**, When did you complete all three injections?_______

Are you allergic to any medications? ☐Yes☐No ☐Penicillin ☐ Codeine ☐Iodine ☐ Latex ☐ Tape ☐ Other _______

List all medications that you are presently taking: ____

____

Total Pregnancies:	How many?	List year for each and type of delivery:
Full-Term		
Pre-term		
Living		
Adopted		
Miscarriage		
Abortion		

Have you ever had Surgery? ☐Yes ☐No If yes what and when? Explain: _______________________________________

____

Have you ever been in any major Accidents/Hospitalizations? ☐Yes ☐No If yes, Explain: _________________________

____

Level of Education: Grade school_______ High School_______College_______***Post Graduate*_________**

Is there anything else regarding your health that the doctor needs to know?

____

FAMILY HISTORY: PLEASE LIST BELOW IF YOU OR ANYONE IN YOUR FAMILY HAS HAD ANY OF THE FOLLOWING:

SELF	***Condition: CHECK BELOW***	***Family Member***	***(FATHER SIDE) LIST below Father , sister ,brother, aunt, uncle, grandparent***	***(MOTHER SIDE) List below Mother, sister ,brother, aunt, uncle, grandparent***
☐	Asthma	☐		
☐	Cancer: (specify, what kind)	☐		
☐	Diabetes	☐		
☐	Endometriosis	☐		
☐	Epilepsy	☐		
☐	Fibroids	☐		
☐	Heart Disease or Murmur	☐		
☐	Hepatitis	☐		
☐	High Blood Pressure	☐		
☐	High Cholesterol	☐		
☐	Kidney/Liver Disease	☐		
☐	Lung Problems: (specify)	☐		
☐	Migraine Headaches	☐		
☐	Musculature: (specify)	☐		
☐	Nervous Condition	☐		
☐	Severe Depression	☐		
☐	Skeletal issues:(specify)	☐		
☐	Stroke	☐		
☐	Suicidal Thoughts	☐		
☐	Thyroid Condition	☐		
☐	Ulcers	☐		
☐	Other: (specify)	☐		
☐	Other: (specify)	☐		

Do YOU have or have you had any of the following:

☐ ***Anemia***	☐ ***Hemorrhoids***	☐ ***HIV***	☐ ***Chlamydia***
☐ ***Blood Transfusions***	☐ ***Infertility***	☐ ***Herpes***	☐ ***Crabs***
☐ ***Urinary Tract Infection***	☐ ***Painful Periods***	☐ ***Syphilis***	☐ ***Trichomonas***
☐ ***Bone Density When:*** ☐ ***Colonoscopy When:***	☐ ***Pelvic Infections***	☐ ***Gonorrhea***	☐ ***Genital Warts***

Do you currently or have a history of Smoking	☐ ***Yes***	☐ ***NO***	***If yes how much? ____ How long? _____when did you quit?_______***
Do you exercise regularly?	☐ ***Yes***	☐ ***No***	***If yes how often? __________***
Do you drink Coffee/Tea/Cola?	☐ ***Yes***	☐ ***No***	***If yes how much/often_____________***
Do you drink Alcohol?	☐ ***Yes***	☐ ***No***	***If yes, how much/often______________***
Have you ever used Marijuana?	☐ ***Yes***	☐ ***No***	***If yes, how much/often/when___________***
Have you ever used Cocaine?	☐ ***Yes***	☐ ***No***	***If yes, how much/often/when___________***
Have you ever used Heroin?	☐ ***Yes***	☐ ***No***	***If yes, how much/often/when___________***

Do you accept blood transfusions? ☐ **Yes** ☐ **No**

Patient Name

FAMILY HISTORY OF CANCER			SELF	WHICH FAMILY MEMBER (Consider parents, children, siblings, aunts/uncles, nieces/nephews, and grandparents	
				MOTHERS SIDE	FATHERS SIDE
Y	**N**	EXAMPLE: Breast Cancer BEFORE AGE 50	------	-----------	**Aunt, age 48**
Y ☐	**N** ☐	Ovarian **OR** Pancreatic Cancer, 1st or 2nd Degree relative, ***at any age***			
Y ☐	**N** ☐	Breast Cancer, 1st **OR** 2nd degree relative ***BEFORE AGE 50***			
Y ☐	**N** ☐	***YOU*** had/have breast cancer ***AT ANY AGE***			
Y ☐	**N** ☐	3 or more breast cancers ***AT ANY AGE, Same side of Family***			
Y ☐	**N** ☐	Ashkenazi Jewish ancestry and 1 breast cancer ***AT ANY AGE, 1ST 2ND , OR 3RD degree relative***			
Y ☐	**N** ☐	Triple negative Breast Cancer, ***Before Age 60*** (ER, PR HER negative receptor status)			
Y ☐	**N** ☐	Male Breast cancer ***AT ANY AGE*** ***OR*** Aggressive Prostate Cancer (Gleason>7)			
Y ☐	**N** ☐	One 1st degree relative with colon or uterine (endometrial) cancer, ***BEFORE AGE 50***)			
Y ☐	**N** ☐	Two 1st degree relative with colon or uterine (endometrial or *Lynch cancers, ***ONE BEFORE AGE 50, Same Side of Family***			
Y ☐	**N** ☐	Three or more colon, uterine (endometrial or *Lynch cancers ***AT ANY AGE, Same side of family***			
Y ☐	**N** ☐	***YOU*** have/had colon or uterine (endometrial) Cancer ***BEFORE AGE 65***			
Y ☐	**N** ☐	Have any of your family members been tested for Brac I or II			

PLEASE HAVE ALL FORMS COMPLETED BEFORE APPT. THANK YOU