Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

Please visit our website at: **www.tbchs.org**

NEW PATIENT WELCOME PACKET

We are a Patient Centered Medical Home:

A Medical Home is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

Locations

Hillman Office: 15774 State Street, P.O. Box 427, Hillman, MI 49746	(989) 742-4583
Atlanta Office: 11899 M-32 West, P.O. Box 850, Atlanta, MI 49709	(989) 785-4855
Thunder Bay Pharmacy Atlanta:	(989) 785-5535 Rx
Rogers City Office: 205 S. Bradley Hwy, Rogers City, MI 49779	(989) 734-2052
Onaway Office: 21258 W. M-68 Hwy, P.O Box 722, Onaway, MI 49765	(989) 733-2082
Thunder Bay Pharmacy Onaway:	(989) 733-7037 Rx
Onaway School Based Health Center: 4549 M-33 Hwy, Onaway, MI 49765	(989) 733-4980
Cheboygan School Based Health Center: 905 W. Lincoln, Cheboygan, MI 49721	(231) 597-9585

How to become an established patient of Thunder Bay Community Health Service, Inc.

Contact one of our offices and request to select a primary care provider and schedule a new patient appointment. Our staff will schedule you for an initial appointment. Please note that this initial appointment does not establish you as a patient of Thunder Bay Community Health Service (TBCHS) until your provider can determine if we can meet your healthcare needs.

Before your initial appointment….

It is important you return this completed packet before your initial appointment if possible. This information is helpful for our providers when addressing all of your healthcare needs. Your initial appointment is usually 45 minutes long and we ask you to arrive 15 minutes early. Bring your medications and any insurance information with you. If you are unable to keep your scheduled appointment, please contact us as soon as possible to cancel and reschedule. TBCHS offers discounted fees to qualified patients to reduce the cost of your healthcare at our facility or participating pharmacies and assistance with transportation. Ask the receptionist for more information.

You are scheduled for an initial appointment with:		
Date:	**Time:**	**Location:**

Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

Patient Information

Patient Name: _____ Today's Date: _____

Address: _____ City: _____State:_____

Zip Code: _____Date of Birth: _____ Marital Status: _____

Telephone Home: (___) _____ Mobile: (___) _____ Email: _____

Soc. Sec. Number: _____ Race: _____ Gender: _____

Insurance Company: _____

Subscriber Name: _____Insured Date of Birth: _____

Relationship to Insured: _____Policy/Group Number: _____

Parent or Guardian Name: _____Address:_____

City: _____State:_____Zip Code: _____Telephone:_____

Emergency Contact Name: _____Telephone:_____

Employer: _____Telephone:_____

Please list all doctors, specialists, clinics or hospitals that have treated you in the past three years.

_____

_____

Have you ever been discharged from a physician's office? _____If yes, why? _____

_____

We provide enrollment assistance for Medicaid, the Health Insurance Marketplace and other health insurance programs. Would you like us to contact you about this? ____Yes ____No

TBCHS provides transportation assistance for appointments at TBCHS. Would you like us to contact you about this? ____Yes ____No

Do you have an **Advance Directive**? _____*An **Advance Directive** tells your healthcare provider of your desire for medical treatment should you become incapacitated or are no longer able to make your own healthcare decisions. Our clinic has these forms available upon your request. Please ask your healthcare provider for this document.*

Patient Name: _____Date of Birth: _____

*****Notice*****

TBCHS may obtain a MAPS (Medication Automated Prescription System) report from the State of Michigan that will provide us with a list of all *controlled* medications you have been prescribed. This report will provide us with the date the prescription was written, by whom, where it was filled, type of medication, dosage and quantity.

If you use *controlled* medications please be aware that TBCHS requests patients who are prescribed controlled medications to read, sign and abide by the terms of a Controlled Substance Contract. This agreement lists guidelines for prescribing and usage of controlled medications well as patient responsibilities. TBCHS providers adhere to this agreement very closely and reserve the right to refuse to prescribe controlled medications.

After Hours Care: TBCHS offers 24-hour call availability for questions or health concerns. For after hours care, please call Alpena Regional Medical Center at (989) 356-7390 and ask to speak with the Thunder Bay Community Health Service provider or dentist on call. The provider or dentist will return your call and make recommendations for care based on the symptoms and/or complaints described.

ALLERGIES: _____

_____

Medication List

List **CURRENT MEDICATIONS** and reasons for taking: (Include vitamin supplements and over the counter medications) attach a separate page if necessary.

Name of Medication:

_____

_____

Past Medical History:

_____

_____

Past Surgical History:

_____

_____

Family History:

_____

_____

Review of Systems

Patient Name: _____ Date of Birth: _____

Please check any areas that are a problem for you now or have been a problem in the past.

General	Respiratory and Breast	Skin

_____ Loss of Appetite	_____ Cough	_____ Rash
_____ Chills	_____ Difficulty Breathing	_____ Hives
_____ Dizziness	_____ Shortness of Breath	_____ Redness
_____ Fatigue	_____ Excessive Sputum	_____ Itching
_____ Fever	_____ Coughing up Blood	_____ Dryness
_____ Continued Fever	_____ Wheezing	_____ Suspicious Lesions
_____ Headache	_____ Chest Pain	_____ Athletes Foot
_____ Feeling Ill	_____ Breast Changes	**Heme/Lymphatic**
_____ Sweats	_____ Breast Lump	_____ Abnormal Bruising
_____ Night Sweats	_____ Nipple Discharge	_____ Bleeding
_____ Sleep Disorder		_____ Enlarged Lymph Nodes
_____ Weight Loss		
Eye	**Gastrointestinal**	**Neurologic**
_____ Blurry Vision	_____ Nausea	_____ Muscle Impairment
_____ Double Vision	_____ Vomiting	_____ Weakness
_____ Irritation	_____ Cramps	_____ Numbness / Tingling
_____ Discharge	_____ Diarrhea	_____ Seizures
_____ Vision Loss	_____ Bloody Diarrhea	_____ Slurred Speech
_____ Eye Pain	_____ Watery Diarrhea	_____ Feeling Faint
_____ Eye Swelling	_____ Constipation	_____ Tremors
_____ Droopy Eye Lids	_____ Change in Bowel Habits	_____ Vertigo
_____ Sensitivity to Light	_____ Abdominal Pain	_____ Paralysis on Both Sides
_____ Redness	_____ Blood in Stool	
_____ Itching	_____ Black / Tarry Stool	
	_____ Jaundice	
	_____ Urge to Defecate	
Ears, Nose, and Throat	**Genitourinary**	**Psychiatric**
_____ Earache	_____ Incontinence	_____ Depression
_____ Ear Discharge	_____ Incomplete Emptying	_____ Anxiety
_____ Ringing in Ears	_____ Pain with Urination	_____ Memory Loss
_____ Decreased Hearing	_____ Burning with Urination	_____ Mental Disturbance
_____ Nasal Congestion	_____ Urinary Urgency	_____ Suicidal Ideation
_____ Nose Bleeds	_____ Urinary Frequency	_____ Hallucinations
_____ Runny Nose	_____ Blood in Urine	_____ Paranoia
_____ Sore Throat	_____ Menstrual Period Absence	_____ Feeling Stressed
_____ Hoarseness	_____ Heavy menstrual Period	_____ Hearing Voices
_____ Difficulty Swallowing	_____ Prolonged Menstrual Period	**Allergic / Immunologic**
_____ Dry Mouth	_____ Abnormal Vaginal Bleeding	_____ Hives
_____ Tooth Pain	_____ Vaginal Discharge	_____ Swelling
_____ Bleeding Gums	_____ Vaginal Itching	_____ Hay Fever
_____ Swollen Glands	_____ Foul Odor	_____ Persistent Infections
	_____ Pelvic Pain	_____ HIV STI Exposure
	_____ Genital Sores	
Cardiovascular	**Musculoskeletal**	**Endocrine**
_____ Chest Pain	_____ Back Pain	_____ Cold Intolerance
_____ Palpitations	_____ Joint Pain	_____ Heat Intolerance
_____ Feeling Faint	_____ Other Pain	_____ Excessive Thirst
_____ Trouble Breathing with Exertion	_____ Joint Swelling	_____ Excessive Hunger
_____ Shortness of Breath Laying Down	_____ Body Aches	_____ Excessive Urination
_____ Shortness of Breath at Night	_____ Muscle Aches	_____ Weight Loss
_____ Peripheral Edema	_____ Muscle Cramps	_____ Weight Gain
_____ Elevated Blood Pressure	_____ Muscle Weakness	
_____ Decreased Heart Rate	_____ Stiffness	
_____ Recent Injury		

Personal Health History

Patient Name: _____ Date of Birth: _____

Provider Name: _____ Date: _____

Please answer the following questions to the best of your knowledge.

Exercise	
Please circle any of the following exercise activities that you regularly participate in.	Aerobics Biking Running Walking Weights Yoga Cardio
If other please specify	
How many days per week do you spend exercising	
Diet	
How many meals do you eat a day?	1 2 3 4+
Do you feel like you have enough calcium in your diet?	Yes No
Do you try to limit your fatty foods?	Yes No
Do you eat fiber enriched foods?	Yes No
Do you drink caffeine?	Yes No
How many 8 ounce cups per day?	
How many 12 ounce sodas per day?	
Do you have enough money for food?	Yes No
Have you had any recent weight changes of 10 pounds or more in the past 6 months?	Yes No
Health Education	
Do you use sunscreen?	Yes No
Do you spend extensive time in the sun?	Yes No
What was the date of your last dental exam?	
How many dental exams do you have in a year?	
What was the date of your last vision exam?	
How many vision exams do you have per year?	
Do you wear corrective lenses?	Yes No
When was your last hearing screen?	
Are you hearing impaired?	Yes No
Are you sexually active?	Yes No
Have you had any recent fractures?	Yes No
Do you do a monthly self breast exam?	Yes No
Do you do a monthly testicular exam?	Yes No
Are you independent with the following activities? Bathing, Dressing, Toileting, Feeding	Yes No
Safety	
Do you wear your seatbelt routinely?	Yes No
Do you wear a helmet routinely?	Yes No
If you have firearms in your home, do you have any safety concerns	Yes No
Home Safety	
Do you have a working smoke detector in your home?	Yes No
Do you have a working carbon monoxide detector?	Yes No
Do you have any concerns about violence or abuse?	Yes No
Do you have a history of violence or abuse?	Yes No