Wayne Medical Center

Patient Information

First Name	Last Name	MI	Date of Birth

Street Address	City	State	Zip

Phone Numbers: (Please Check Primary Phone)	☐ Home Phone	☐ Cell Phone	☐ Work Phone

SSN	Gender ☐ Male ☐ Female	E-mail Address

Employment Status ☐Full Time ☐Part Time ☐Retired ☐Unemployment ☐Disabled ☐Student	Employer & Occupation

Race:		Ethnicity:	Marital Status:		Language:
☐ American Indian/Alaskan Native	☐ Asian	☐ Hispanic or Latino	☐ Single	☐ Divorced	☐ English
☐ Native Hawaiian/Pacific Islander	☐ White	☐ **Not** Hispanic or Latino	☐ Married	☐ Widowed	☐ Spanish
☐ Black or African American	☐ Other		☐ Partner	☐ Separated	☐ Other

If you are here for urgent care only please list your primary doctor's name and office information here:

What is the **name** and **location** (city and cross streets) of your **pharmacy**?

What is the reason for your visit today?

Responsible Party (Guarantor)

☐ Same as patient

First Name	Last Name	MI	Date of Birth

Street Address	City	State	Zip

Phone Numbers: (Please Check Primary Phone)	☐ Home Phone	☐ Cell Phone	☐ Work Phone

SSN	Gender ☐ Male ☐ Female	Relationship to patient

Emergency Contact(s)

First Name	Last Name	MI	Relation

Phone Numbers: (Please Check Primary Phone)	☐ Home Phone	☐ Cell Phone	☐ Work Phone

First Name	Last Name	MI	Relation

Phone Numbers: (Please Check Primary Phone)	☐ Home Phone	☐ Cell Phone	☐ Work Phone

Insurance Information

Name of Primary Insurance:	Name of Subscriber	Relationship
Subscriber/Policy/Enrollee ID Number:	**Group Number**	**Birthdate of Subscriber**
Name of Secondary Insurance:	**Name of Subscriber**	**Relationship**
Subscriber/Policy/Enrollee ID Number:	**Group Number**	**Birthdate of Subscriber**

I authorize the release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of Patient or Guardian:	Date:

Wayne Medical Center

Patient Information			
First Name	Last Name	MI	Date of Birth

Past Medical History/Family History

Please indicate any of the following medical problems within your family history:

S = Self C = Children M = Mother F = Father S/B = Sister or Brother GP = Grandparent A/U = Aunt or Uncle

	S	C	M	F	S/B	GP	A/U		S	C	M	F	S/B	GP	A/U
Alcoholism								High Blood Pressure							
Cancer								Mental Illness							
Diabetes								Stroke							
Heart Disease								Other							

Is your mother alive? ☐ Yes ☐ No ☐ Unknown

Is your father alive? ☐ Yes ☐ No ☐ Unknown

How many biological brothers do you have?

How many biological sisters do you have?

How many biological sons do you have?

How many biological daughters do you have?

What medical problems have you been diagnosed with that were not listed above: ____________________

Past Surgical History (i.e. tonsils, gall bladder, hysterectomy, C-section)

Surgery	Hospital	Year

Allergies

Current Medications

(Please list all medications you are currently taking, including over the counter medications you take.)

Name	Strength	Frequency

Social History

Check one of the following about smoking tobacco:

☐ Never smoked ☐ Former smoker ☐ Smoke some days ☐ Smoke every day ☐ Exposed to second hand smoke

If you are a current smoker, how many cigarettes a day do you smoke? ____________________

How soon after you wake up do you have your first cigarette? ____________________

Are you interested in quitting? ☐ Ready to quit ☐ Not ready to quit ☐ Thinking about quitting

Have you had a drink containing alcohol in the last year? ☐ Yes ☐No

If yes, how often? How many drinks in one sitting?

Do you use any recreational drugs or take any controlled medications that are not prescribed to you? ☐ Yes ☐ No

If yes, what type(s) and how often?

Wayne Medical Center

Acknowledgment of Receipt of Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act (HIPAA), you have certain Patient Rights regarding your protected health information. Wayne Medical Center has a detailed document called the "*Notice of Privacy Practices*". It contains a complete description of your right to privacy and how we may use and disclose protected health information.

You understand that you have the right to read the "Notice" prior to signing this acknowledgement. You may request a copy of the most current *Notice of Privacy Practices* at any time.

Your signature below indicates that you have been given the chance to review such a copy of Wayne Medical Center's *Notice of Privacy Practices*. Your signature means that you agree to allow Wayne Medical Center to use and disclose your protected health information to carry out treatment, payment, and health care operations. Unless required by law, there will be no other uses and disclosures of this information without your consent. you have the right to revoke this consent in writing at any time, except to the extent that Wayne Medical Center has taken action relying on this consent.

If you have any questions regarding the information contained in the *Notice of Privacy Practices*, please contact our privacy officer.

____

Patient/Parent/Guardian Signature **Date**

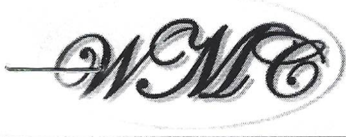
____

Printed Name of Patient/Parent/Guardian **Relationship** **Patient's DOB**

For Office Use Only
We attempted to obtain written acknowledgment of patient's receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained from the patient for the following reason: □ Individual refused to sign □ Communications barriers prohibited obtaining the acknowledgement □ An emergency situation prevented us from obtaining signature □ Other (please specify) ______________________________ ______________________________ ______________________________ Registration Rep. Signature:______________________________Date:____________ Privacy Officer Signature:______________________________Date:____________

Phone: (734)729-5780 Fax: (734)729-7730

1203 S. Wayne Rd., Westland, MI 48186



Wayne Medical Center

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is as accurate as possible. Some pharmacies do not make drug history information available, and your drug history may not include drugs purchased without using your health insurance. Also, over-the-counter medications, supplements, and/or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescriptions to treat HIV/AIDS and medications used to treat mental health issues.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

____

Patient/Parent/Guardian Signature **Date**

____

Printed Name of Patient/Parent/Guardian **Relationship** **Patient's DOB**

Please note: Michigan does not require consent to obtain history of Controlled Substances. This facility utilizes the Michigan Automated Prescription System in partnership with the state to assist in the prevention of controlled substance abuse, and to ensure the health and safety of our community.

☐ I decline to give permission to obtain my medication history. Reason:______________________________

____

____

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www.waynemed.com

Wayne Medical Center

The Patient-Doctor Partnership

The health and wellness of our patients is a top concern of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, your Doctor, and you, my patient, work together. This concept is called the Patient Centered medical Home (PCMH)

Patient Responsibilities:

- Ask questions, share your feelings, and be a part of your care.
- Be honest about your history, symptoms, and other important information about your health.
- Tell your Doctor about any change in your health and wellbeing.
- Take all of your medicine and follow your Doctor's advice.
- Make healthy decisions about your daily habits and lifestyle.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible.
- Call your Doctor first with all problems, unless it is a medical emergency.
- End every visit with a clear understanding of your Doctor's expectations, treatment goals, and future plans.

Doctor Responsibilities

- Explain diseases, treatments, and results in an easy-to-understand way.
- Listen to my patient's feelings, questions, and help them make decisions about their care.
- Keep treatments, discussions, and records private. However, your health care information is shared among care partners as necessary.
- Provide 24 hour access to medical care and same day appointment, whenever possible. Provide instructions on how to meet your health care needs when the office is not open.
- To care for you to the best of my abilities based on my understanding of current medical methods available. Give my patients clear directions about medicines and other treatments.
- Send my patients to trusted experts, if needed.
- End every visit with clear instructions about expectations, treatment goals and future plans.

Patient Name:____________________ Provider Name: Modini Liyanage, MD

Patient Signature:____________________ Provider Signature:____________________

Date:____________________ Date:____________________

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