Welcome to
Livonia Family Medicine

LISA ANNE BRAWLEY, M.D. PC

Please provide us with the following information so we may better serve you. Any information you provide will be kept confidential as part of your medical record. It is not mandatory that you provide any of the following information in order to receive medical services.

Patient Name ____

Birth Date _________ Gender __________ Marital Status _______________________

Address ___________________________ Phone number_______________________

City ______________________ State ________ Zip Code _______________________

Employer _______________________ Work phone _______________________

Occupation_________________________ Cell phone _______________________

Email Address ____
Email address is used for you to have access to your medical records, we won't send you junk

If child, parent or guardian's name_____________________ Relationship ___________

Spouse's name ____

Emergency Contact name __________________________ Relationship ___________

Emergency Contact address ________________________ Phone Number__________

Medical Insurance Company ________________________Phone Number__________

Insurance Company Address _______________________________________

Insurance Subscriber Name__________________________ Relationship ___________

Policy Number________________________ Group Number _______________________

Contract Number ____

Secondary Insurance Company____

How did you find out about our office?
Newspaper ___ Flyer___ Signage___ Medical Referral ___ Personal Referral _____
Phone Book ___ (SBC or Yellow Book) Internet___ Other______________________

I authorize Livonia Family Medicine to release information necessary to file an insurance claim if I am using health care insurance. I understand that I am responsible for all charges, regardless of insurance coverage, and billing charges to my insurance company is done as a courtesy by this office.

Patient or parent or guardian signature ________________________Date___________

Livonia Family Medicine
L I S A   A N N E   B R A W L E Y ,   M . D .   P C
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Patient Privacy Practices Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance and Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice may condition treatment upon the execution of this Consent.

Relationship to Patient (if other than patient): ______________________________

This Consent was signed by: ______________________________ ____________________
Patient or Representative Date

Witness: ______________________________
Practice representative

Patient Health Care Questionnaire

Name ____Date ___________

1. When was your last comprehensive health examination (blood tests, EKGs, etc.)?
Date: ___/____/____ *Note: We recommend a comprehensive evaluation for healthy individuals every three years until age 40, every two years from ages 40 to 50 and annually after the age of 50. Patients with a chronic medical problem should have an annual health evaluation.*

2. Do you have a family history of medical, mental, substance abuse or hereditary problems?
Yes □ No □ Please list:_____________________________________
____
____

3. If you were born after 1957, have you had a second measles, mumps and rubella vaccination?
Yes □ No □

4. If you are at least 65 years old or have a chronic health problem, have you received the pneumococcal, shingles, and flu vaccines?
Yes □ No □

5. If you are a female do you do a monthly self-breast exam?
Yes □ No □
What is the date of your last breast exam by your physician: ____/____/____?
What is the date of last mammogram: ____/____/____?
Date of last Pap smear: ____/____/____?

Note: One out of every 10 women will get breast cancer. *The best approach is early detection by doing a monthly self-breast exam, an annual breast exam by your physician and periodic mammograms after age 40.*

6. If you are over age 50, have you had a colonoscopy to screen for colon cancer? Date of last colonoscopy: _____/_____/______. *Screening colonoscopy is recommended every ten years for everyone over 50, earlier for people with family history of colon cancer or symptoms of colon cancer.*

7. If you are a male, do you do a monthly self-testicular exam? ***Note: Testicular cancer is a leading cause of cancer for men under the age of 50.***
Yes □ No □

8. Do you always practice “safe sex”?
Yes □ No □

9. Are you at risk for AIDS?
Yes □ No □

10. Have you used illegal drugs or prescription drugs in an illegal manner?
Yes □ No □

11. Have you ever been exposed to chemicals or radiation at the workplace?
What is your occupation? ________________________
Yes □ No □

12. Do you have a living will?
Yes □ No □

13. Do you text and drive?
Yes □ No □

14. If you ride a bicycle, do you wear a bike helmet?
Yes □ No □

15. Is your home tobacco and smoke-free?
Yes □ No □

16. Is your time well balanced between your job, family and hobbies?
Yes □ No □

17. Do you always use your seat belt in the car?
Yes □ No □

18. Do you drink alcohol?
Yes □ No □

19. Do you exercise regularly?
Yes □ No □

20. Do you follow any special diet (vegetarian, low carb, diabetic, etc.)?
Yes □ No □

21. Do you smoke cigarettes or cigars?
Yes □ No □

22. Do you have any allergies to medications?
Yes □ No □ Please list:____
____
____

23. Have you ever had surgery?
Yes □ No □ Please list:____
____
____

24. Have you ever been hospitalized for something other than surgery?
Yes □ No □ Please list:____
____
____

25. What did you want to talk to the doctor about today?

____