NEW PATIENT INFORMATION

Date:_____ **Name:** _____ **Birthdate** _____ **Sex** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Email Address_____

Occupation: _____ **SSN#:** last 4 digits only _____

PLEASE CIRCLE

Married Single Widowed Divorced Domestic Partner Legally Separated Life Partner

Sexual orientation: homosexual, heterosexual, Bisexual, Choose not to disclose

Gender identity: Identifies as Male/ Female, Transgender,Choose not to disclose

Assigned sex at birth: Male, Female, Choose not to disclose

Pronouns: he/him, she/her, they/them

PATIENT'S ETHNICITY

_____Hispanic or Latino _____Not Hispanic or Latino _____Unreported/Refused to Report

RACE:

_____Asian _____Black/African American _____American Indian/Alaska Native _____White

_____ Unreported/Refused to Report

PREFERRED LANGUAGE:

_____English _____Indian (including Hindi & Gujarati) _____Spanish _____Other

CONTACT INFORMATION:

Primary Phone: _____Home Cell Work Other:_____
Secondary Phone: _____Home Cell Work Other:_____

Name and telephone number of someone to reach in case of an emergency,

_____

NAME PHONE RELATIONSHIP

Synergy Medical

Patient Name_____**Birthdate:**_____**Physician:**_____

Thank you for choosing Synergy Medical PC as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Patient Financial Responsibility Policy, which we require you to read and sign prior to seeing the physician. Please let us know if you have any questions or concerns.

I understand all copayments, co-insurance and past due balances are due and payable at the time of service. For your convenience, we accept cash, check, Visa, MasterCard, American Express, and Discover.

I understand I am financially responsible for treatment provided to me or my legal dependent by Synergy Medical PC. This includes physicals, office visits, procedures, lab or diagnostic testing ordered by my physician.

I understand my insurance policy is a contract solely between me and my insurance company. It is my responsibility to know if my insurance company has any deductibles, copayments, co-insurance, out-of-network or benefit limitations for medical, lab or diagnostic services. I understand that, as a courtesy, my physician will submit a claim to my insurance plan. I authorize my insurance plan to make payments for covered services directly to my physician.

I authorize Synergy Medical PC to communicate with my health insurance company, in accordance with their Privacy Policy, regarding my policy coverage. I further authorize Synergy Medical PC to release information required by my insurance company to make payment for services rendered.

If there is a balance on my account, a statement of my charges and payment will be sent to my mailing address. A payment plan may be set up if I have financial difficulties.

I understand appointment cancellations with less than 24 hour notice or "No Show" patients can be charged a service fee of up to $20.00 for missed office visit. I understand I am responsible for this fee. I understand it cannot be billed to my insurance plan.

I have read the Patient Financial Policy and understand my responsibilities.

_____ _____

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date

Synergy Medical

Communicate with us securely ONLINE

The **"Patient Portal"** is a service we provide to our patients that integrates with our electronic medical record and provides more efficient service to you.

THE PATIENT PORTAL SHOULD ONLY BE UTILIZED FOR ROUTINE MATTERS AND SHOULD **NOT** BE UTILIZED FOR URGENT ISSUES.

Services that are available in the **"Patient Portal"**:

- Request medication refills
- Receive test results
- Request referrals to specialists
- Instant access to your medical records
- Ask your physician a question

Access the Patient Portal at www.drgandhimd.com

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Complete the information listed below. Once this form is received, you will be given a temporary password that you need to create your portal account.

Patient's First Name: _____ Patient's Last Name: _____

Patient's Birth Date: _____

Patient's CURRENT Email address: _____

Synergy Medical

MEDICAL HISTORY FORM

Name: (last) _____ (first) _____ Date of Birth: _____SEX: M/F
Mail Order Pharmacy:_____ Phone:_____
Local Pharmacy:_____ Phone:_____
Language Spoken at home:_____

MEDICATIONS:
Please list all medications (include over-the-counter?)

In preparation for your visit bring all medications, inhalers, Vitamins, or supplements in their original bottles.

NAME STRENGTH FREQUENCY

1._____
2._____
3._____
4._____

ALLERGIES:
Are you allergic to any drugs or medications?

☐ NO ☐ YES If yes, what

Do you have any food allergies?

☐ NO ☐ YES If yes, what?

5._____
6._____
7._____
8._____

FAMILY HISTORY: (Cancer/BP/Diabetes/Bleeding Disorder/Anemia, etc.)

MOTHER: _____ BROTHER: _____

FATHER: _____ SISTER: _____

OTHER: _____

ADVANCED DIRETIVES – Y/N

LAST MAMMOGRAM – *FACILITY-*

LAST COLONOSCOPY- *FACILITY-*

PAST MEDICAL HISTORY/SURGERY

1._____ 2._____

3._____ 4._____

Synergy Medical PC
9216 Middlebelt Rd, Livonia, MI 48150
Phone :734-427-3500 Fax: 734-427-9234

Patient Centered Medical Home (PCMH)

Patient / Provider Partnership Agreement

We are always looking for ways to better coordinate your healthcare needs. With this in mind, our office has moved toward the Patient Centered Medical Home (PCMH) care model.

As a PCMH, our team will look at how we can best coordinate your healthcare needs. This comprehensive and proactive way of managing your care is meant to improve the quality of your office visits as well as your overall health. Your primary care physician (PCP) will lead the team that will provide on-going care, with the goal of improving your health through a patient-provider relationship.

Some benefits and expectations of PCMH are below:

Provider Responsibilities:

- A physician directed healthcare team.
- Goal setting and care plan developed with you, your family and healthcare team.
- Increased appointment availability, extended office hours and/or access to urgent care services, as needed, including same-day and telemedicine appointments.
- Referrals and coordination of care with trusted specialists, and community resources, as needed.
- Sharing health information with care partners to overall improve quality and comprehensive care.
- Set communication expectations regarding test results and other medical services.

Patient Responsibilities:

- Ask questions, share your feelings and be an active participant in your healthcare discussions.
- Be honest when asked about your health history, symptoms, & other important info about your health.
- Call your PCP first with any medical problems unless a medical emergency.
- Bring any test results done by other physicians back to your PCP's office.
- Follow your treatment plan created by your provider and care team members, including filling and taking medications as directed.
- End each visit with a clear understanding of expectations, treatment goals, and future plans.
- Keep appointments.