Board Certified Internal Medicine
Tanir Medical Center P.C.
6080 Dixie Hwy Ste B Clarkston, Michigan
Telephone: 248-620-3700 Fax: 248-620-0228
www.TanirMedicalCenter.com

Patient Registration

Patient Name: _____________________________ DOB: _______________ SS#______________________

Address:____ Occupation: _______________

City: ______________________ State: _________________ Zip Code: ________________ Sex: **M**☐ **F** ☐

Email: ________________________________ Work Phone: ______________________________________

Home Phone: _________________________________ Cell Phone: ________________________________

Insurance Card Holder

Card Holder Name: _____________________ DOB: ___________________ SS# _______________________

PRIMARY INSURANCE

Type: ____________________________ Copay Amt: _________ Effective Date: ______________________

Prefix: __________________ Contract #: ____________________________ Group: __________________

Employer: ____ Sev Code: ____________________________

SECONDARY INSURANCE

Type: ____________________________ Copay Amt: _________ Effective Date: ______________________

Prefix: __________________ Contract #: ____________________________ Group: __________________

Employer: ____ Sev Code: ____________________________

TERTIARY INSURANCE

Type: ____________________________ Copay Amt: _________ Effective Date: ______________________

Prefix: __________________ Contract #: ____________________________ Group: __________________

Employer: ____ Sev Code: ____________________________

*I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO **NARIN TANIR MD** FOR SERVICES RENDERED. I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS BY FAX OR MAIL TO APPROPRIATE PHYSICIANS AND INSURANCE COMPANIES. I AUTHORIZE **NARIN TANIR MD** AND HER REPRESENTATIVES TO PROVIDE MEDICAL CARE. I AUTHORIZE THAT ALL THE INFORMATION BE SHARED WITH HEALTH CARE PROVIDERS INVOLVED WITH MY CARE. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO **NARIN TANIR MD**. I WILL ASSUME RESPONSIBILITY FOR ANY FEES NOT COVERED BY MY INSURANCE COMPANY. DUE TO MANY CHANGES IN INSURANCE POLICIES, IT IS NO LONGER AN EASY TASK TO INTERPRET EACH INDIVIDUAL POLICY. IT IS YOUR RESPONCIBILITY TO KNOW YOUR INSURANCE COVERAGE. FAILING TO COMPLY WITH THIS SUGGESTION COULD RESULT IN YOU, THE PATIENT, BEING RESPONCIBLE FOR ALL COSTS INCURRED. PLEASE REMEMBER YOUR INSURANCE POLICY IS BETWEEN YOU AND THE INSURANCE COMPANY, AND NOT BETWEEN THE INSURANCE COMPANY AND THE DOCTOR. IN THE EVENT THAT I (THE PATIENT) RECEIVE DIRECT PAYMENT OF BENEFITS, I AGREE TO REMIT SUCH FUNDS TO **NARIN TANIR MD**. I ACKNOWLEDGE THAT I RECEIVED AND READ "NOTICE OF PRIVACY PRACTICES."*

Signature: ____ Date: _________________________

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Emergency Contact Information 1

Name: ____

Address:____

City: _____________________ State: _________________ Zip Code: ________________ Sex: **M**☐ **F** ☐

Email: _______________________________ Work Phone: _____________________________________

Home Phone: ________________________________ Cell Phone: _______________________________

Emergency Contact Information 2

Name: ____

Address:____

City: _____________________ State: _________________ Zip Code: ________________ Sex: **M**☐ **F** ☐

Email: _______________________________ Work Phone: _____________________________________

Home Phone: ________________________________ Cell Phone: _______________________________

Emergency Contact Information 3

Name: ____

Address:____

City: _____________________ State: _________________ Zip Code: ________________ Sex: **M**☐ **F** ☐

Email: _______________________________ Work Phone: _____________________________________

Home Phone: ________________________________ Cell Phone: _______________________________

Signature:___________________

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Patient Name: ______________________________ DOB: ________________ SS#______________________
Address:____ Occupation: ________________
Phone (Home): _________________________________ Phone (work): _______________________________
Chief Complaint: ____ Date: _______________

Drug Allergies

____
____
____
____
____
____

Current Meds

____
____
____
____
____
____

Family History:

	Father	Mother	Parents	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date

WOMAN ONLY: Are You Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

Medical History

☐ Headache
☐ Shortness of Breath
☐ Heart Palpitations
☐ Heart Murmur
☐ Chest Pain
☐ Dizziness/Fainting
☐ Peripheral Vascular Disease
☐ Allergies/Hay Fever
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Ulcer
☐ GI disorder
☐ Lactose Intolerance
☐ Gallbladder disease
☐ Prostate Disease
☐ Bowel Irregularity
☐ Incontinence
☐ Sexual/Menstrual Dysfunction
☐ Venereal Disease
☐ Frequent Infections
☐ Hepatitis
☐ Anemia
☐ Arthritis
☐ Osteoporosis
☐ Nervousness
☐ Depression
☐ Gout
☐ Scarlet Fever
☐ Chronic Rashes
☐ Rheumatic Fever
☐ Mumps
☐ Measles
☐ Rubella
☐ Polio
☐ Diphtheria
☐ Tetanus
☐ Other
☐ Other

Habits

☐ **Smoke** Packs Daily? ___________ How Long? ____________________Interested in stopping? ______________________
☐ **Coffee** Cups Daily? _________ Other Caffeine? _________ ☐ Alcohol Type? ______________ Amt_______________
☐ **Diet** Salt Intake? ___________ Fat Intake? _____________ ☐ Exercise Routine ______________________________
☐ Sleep Difficulty falling asleep? ________ Continuity Disturbances? ___________ Snoring? ________
Early Morning Awakening? ___________________ Daytime Drowsiness? ___________________ Other? _______________

Hepatitis C Risk Factor

☐ Blood Transfusion prior to 1992
☐ Contact with blood/bodily fluid
☐ Shared razor/toothbrush
☐ IV drug use
☐ Tattoos
☐ Body Piercings

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____ date ____________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Medical Information Release Form
(HIPAA RELEASE FORM)

Name: ____ DOB: _________________________________

RELEASE INFORMATION

□ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

- □ Spouse: ____
- □ Child (ren): ____
- □ Other: ____

□ Information is not to be released to anyone.

THIS **RELEASE OF INFORMATION** WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

Please Call: □ My Home □My Work □My Cell Number : _______________________________

If unable to reach me:

- □You may leave a detailed message
- □Please leave a message asking me to return your call
- □__________________________________

The best time to reach me is (day) __________________ between (time) __________________________

Signature: ____ Date: ______________________

Witness: ____ Date: _______________________

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Opiate Contract Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines.
- In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I would also be amendable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my doctor deems necessary.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc. nor will I misuse or self-prescribe/medicate with legal
- I am not driving, operating machinery and will be infrequent.
- I will not share my medication with anyone.
- I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or any anti-anxiety medications from any other doctor.
- I will safeguard my pain medication from loss or theft. Lost or stolen medications will not be replaced.
- I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours.
- No refills will be available during evenings or weekends

I agree to use: _________________

Name of Pharmacy: ___________________, Located at: ________________

Number: ___________ for filling my prescriptions for all of my pain medication

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care physician and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

- I agree that I will submit to a blood or urine test if requested to by my doctor to determine my compliance with my program of pain control medications.
- I agree that I will use my medicine at a rate no greater than that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will bring unused pain medicine to every office visit
- I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this ______ day of ________, 2018

Patient Signature: ____

Physician Narin Tanir Avci: ____________________________________

Witnessed by: ____

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Patient Name: ______________________________ Date: _________________________________

We are pleased to assist you with your medical insurance. If you have medical insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average. **If you provide our office with false or inactive insurance information it is YOUR financial responsibility to cover the full costs of your visit.**

COPAYS: I understand that I am responsible to pay all co-payment at the time of service, prior to being seen.

DEDUCTABLE: If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services.

I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

PARENT SIGNATURE/GUARDIAN: ___________________________________DATE:_________________

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Patient Questionnaire - PHQ-9*
Nine Symptom Checklist

Patient Name: ____ Date: _________________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around allot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10. If you checked off any problem in this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				

Make an appointment with your physician or healthcare professional to discuss your results

* Adapted from PRIME-MD