Lascelles Pinnock, M.D.

14575 Southfield Rd.
Allen Park, Mi. 48101

22255 Greenfield Ste. 200
Southfield, Mi. 48075

CONFIDENTIAL MEDICAL HISTORY FORM

Name _____ **Birthdate** _____ **Date** _____

Do you: **Smoke?** _____ **Packs per day** _____ **# Years smoked** _____

Drink Alcohol? _____ **Drinks per day** _____

Drink cola/coffee? _____ **How much per day?** _____

List the medications you are now taking:_____ _____
_____ _____ _____

List any allergies you have to drugs, food or other items:_____
_____ _____

Do you use any type of street drugs i.e. marijuana, cocaine, methamphetamine, etc. yes__ no__

Are you currently under medical care for any reasons? If yes, please explain:

Primary Care Physician: Name: _____

Address and City: _____

Phone: _____

Past Psychiatric/Mental Health Care:

Therapist's Name: _____ **For How Long and When:** _____

List All Operations:

Operation Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

List all times you have been admitted to a hospital overnight (except for childbirth)

Reason Hospitalized	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

WOMEN ONLY:

Date of last period ___/___/_____
Are you Pregnant yes___ no___ Any chance you are pregnant yes__ no__

Lascelles Pinnock, M.D.

14575 Southfield Rd.
Allen Park, Mi. 48101

22255 Greenfield Ste. 200
Southfield, Mi. 48075

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: _____	**Kidney Disease: _____**	**Asthma: _____**
Stroke: _____	**Bleeding Tendencies: _____**	**Tuberculosis: _____**
Cancer: _____	**Seizures: _____**	**Colitis: _____**
Emphysema: _____	**Heart Disease: _____**	**Anemia: _____**
Ulcers: _____	**Sugar Diabetes: _____**	**Gout: _____**
Mental Illness: _____	**Other Serious Illness: _____**	

Have you had any of the following illnesses: (Please Circle)

Measles	**Diabetes**	**Typhoid**
Rubella (German Measles)	**Goiter, Thyroid Disease**	**Malaria**
Chickenpox	**Hives**	**Other Tropical Diseases**
Mumps	**Allergies**	**Hepatitis**
Whooping Cough	**Eczema**	**Venereal Disease**
Scarlet Fever	**Mono**	**Seizures**
Tonsillitis	**Rheumatic Fever**	**Meningitis**
Diphtheria	**Poliomyelitis**	**Ear Infections**
Asthma	**Pleurisy**	**Heart Murmur**
Glaucoma	**Bronchitis**	**High Blood Pressure**
Cancer	**Influenza**	**Low Blood Pressure**
Angina Pectoris	**Tuberculosis**	**Heart Attack**
Ulcer	**Phlebitis**	**Kidney Stones**
Bladder or Kidney Infection	**CHF**	**Lupus**
Multiple Sclerosis	**HIV/AIDS**	**Other serious illnesses (Please Explain):**

It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

_____ _____

Patient Signature **Date**

Lascelles Pinnock, M.D.

14575 Southfield Rd.
Allen Park, Mi. 48101

22255 Greenfield Ste. 200
Southfield, Mi. 48075

Authorization to Release Health Care Information

Patients Name: _____ Date of Birth: __/__/____

SSN: _____ Maiden Name _____

I request and authorize _____ to release health care information of

the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, dates

or treatment of:_____

_____ All health care information

_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus)l sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____

Signature of patient or patients authorized representative **Date signed**

_____

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative., etc.)

Oakwood

SURGERY BOARDING FORM

❑ Oakwood Hospital & Medical Center
❑ Oakwood Annapolis Hospital
❑ Oakwood Heritage Hospital
❑ Oakwood Southshore Medical Center

Please complete the following information to schedule surgery (please print):

CONTACT INFORMATION (PATIENT TO COMPLETE THIS SECTION)

***Patient Last Name:**		***First Name:**
*Address, City, State, Zip:		
*Home Phone:	Work Phone:	Day of Surgery Contact Phone:
*Alternate Contact:		*Phone Number:
*Date of Birth:	*Age:	*Gender: ❑ Male ❑ Female
*Primary Care Physician:		*Phone Number:
Cardiologist or Referring Physician:		Phone Number:

MEDICAL INFORMATION (PATIENT COMPLETE THIS SECTION)

1. *Do you have a pacemaker or defibrillator?	❑ Yes	❑ No
2. *Are you allergic to latex?	❑ Yes	❑ No
3. Do you have (or have you had) any type of heart problems, diabetes, kidney problems or bleeding and clotting problems?	❑ Yes	❑ No
4. Have you ever had a heart attack or chest pain?	❑ Yes	❑ No
5. Do you take insulin, heart medications, coumadin, plavix or blood thinners?	❑ Yes	❑ No

INSURANCE (PLEASE HAVE PATIENT COMPLETE THIS SECTION FROM THEIR INSURANCE CARD)

***Insurance Name (Primary):**	Insurance Phone Number:	*Subscriber Name: *Subscriber Birth Date:
Policy # (Primary)	Group # (Primary)	
***Subscriber's Social Security Number:**		*Subscriber's gender ❑ **Male** ❑ **Female**
***Insurance Name (Secondary)**	Insurance Phone Number:	*Subscriber Name:
Policy # (Secondary)	Group # (Secondary	*Subscriber's Birth Date: ____/____/____
***Subscriber's Social Security Number:**		*Subscriber's gender ❑ **Male** ❑ **Female**

OR BOARDING REQUEST (PHYSICIAN'S OFFICE USE ONLY)

The following information is required to board any surgical procedure:

****Authorization Number Insurance #1:**		Authorized by:
****Authorization Number Insurance #2:**		Authorized by:
*Surgeon:		Phone # (at chart location):
*Surgery Date:	Requested Time:	*Astnt: ❑ CSA ❑ Res. ❑ PA/RNFA ❑ N/A

*Type of Admission: ❑ Outpatient ❑ 23 Hour ❑ Same-day Admit ❑ Inpatient

*Pre-Op Diagnosis:

*Anesthesia Type: ❑ Local ❑ L-MAC ❑ Regional ❑ General | *Critical Care Bed Req'd: ❑ Yes ❑ No

*Procedure: CPT Code:_____
ICD-9 code:_____

(Circle One): Right or Left

Were Radiology Studies Done? ❑ Yes ❑ No Where were the film/digital images done?_____

Will the patient be bringing the films? ❑ Yes ❑ No

****If done at a non-Oakwood facility, patient is responsible for bringing the films on the day of surgery.***

Scheduler Comment (Oakwood Use): Interpreter Required/Language:

* denotes required information
** Is not required if boarding case 6 months to 2 weeks ahead

Fax to Boarding Office: 313-593-8852