

Steven Allan, NP
Joshua P. Ellwitz, MD
Michael D. Kasten, MD

Dear _____:

Your appointment with Dr. / NP _____ at the Bronson Hospital Medical Office Pavilion (2nd floor) is scheduled on _____ at _____.

To complete your check-in process our staff will scan your personal I.D. or driver's license and insurance card(s) into our computer system. You will be asked to review and sign various forms and verify or update your personal health history and your personal demographic information.

Allow us to review important details to prepare for your visit.

- There are many insurance plans with different benefits and coverage. *Please understand your coverage and authorization requirements.* Your insurance plan may require authorization from your family physician or plan representative before you visit a specialist, and you may be required to do so for every visit. Your insurance company can provide details. Please obtain required authorization(s) before you visit our office.

Bronson is committed to providing you with a caring and positive experience.

Our surgeons are often called to assist an emergency patient. We will make every effort to contact you if your appointment is delayed or cancelled due to an emergency. Please provide our office with a contact number where you can be reached between the hours of 8:00 a.m. and 5:00 p.m., Monday – Friday.

IMPORTANT ITEMS TO BRING WITH YOU:

- **Insurance Card(s)**
- **Photo Identification**
- **Completed forms we included in this packet (Please do not mail forms)**
- **X-Ray Films or CD (if applicable)**

Bronson MyChart:

Bronson MyChart is a free and secure tool that gives you access to parts of your medical record through your own computer or electronic device. You can now renew prescriptions, send non-emergency messages to your physician and request appointments – all online. Whether you

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855.618.2676
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bronsonhealth.com

are at home, at work or on the go, you can see your health information and communicate with your doctor's office using Bronson MyChart. Ask our staff to help you open your account.

If you have questions or need to speak to a staff member before your appointment you may contact us at 855-618-2676, or visit our website at www.bronsonhealth.com. Select *Bronson Spine & Scoliosis Specialists* from the list of practices to view our provider profiles and practice details.

If you need to cancel or reschedule your appointment we appreciate at least 24 hour notice so we may release your appointment time to another patient. A \$25.00 fee may be charged without proper notice.

Thank you for choosing Bronson.

DATE:		DATE OF BIRTH:			
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	
REASON FOR VISIT:			PRIMARY CARE PHYSICIAN:		
PREFERRED PHARMACY AND LOCATION		HEIGHT:	WEIGHT:	BP:	PULSE:
		The Above Items Area For Office Use Only			

SOCIAL HISTORY – ENVIRONMENTAL/BEHAVIORAL RISK FACTORS					COMMENTS
TOBACCO USE:	Current	Former	Never		
ALCOHOL USE:	Current	Non-Drinker			
CAFFEINE USE:	Uses	No use			
SEXUALLY ACTIVE:	Yes	No			
DATE OF LAST MAMMOGRAM :					
DATE OF LAST FLU SHOT:					
DATE OF LAST PNEUMOVAX SHOT:					

FAMILY HISTORY – GENETIC FACTORS: THIS INFORMATION IS ABOUT YOUR <u>FAMILY</u>											
IF YES,WHO?				IF YES,WHO?				IF YES,WHO?			
CARDIOVASCULAR				HEMATOLOGIC				NEUROLOGIC			
Coronary Artery Disease	Y	N		Bleeding Disorder	Y	N		Alzheimer's Disease	Y	N	
Heart Disease	Y	N		Hematologic Disorder	Y	N		Dementia	Y	N	
Hyperlipidemia	Y	N		Hemophilia	Y	N		Migraine	Y	N	
Hypertension	Y	N		Sickle Cell Anemia	Y	N		Stroke	Y	N	
Ischemic Heart Disease	Y	N		MENTAL HEALTH/ SUBSTANCE ABUSE				ONCOLOGIC			
Sudden Death	Y	N		Alcoholism	Y	N		Breast Cancer	Y	N	
ENDOCRINE/ METABOLIC				Attention Deficit Disorder	Y	N		Colorectal Cancer	Y	N	
Diabetes Mellitus	Y	N		Bipolar Disorder	Y	N		Endometrial Cancer	Y	N	
Thyroid Disorder	Y	N		Depressive Disorder	Y	N		Lung Cancer	Y	N	
EYES, EARS, NOSE & THROAT				Mental Disorder	Y	N		Melanoma	Y	N	
Glaucoma	Y	N		Schizophrenia	Y	N		Ovarian Cancer	Y	N	
Hearing Loss	Y	N		Smoking Tobacco	Y	N		Prostate Cancer	Y	N	
Visual Loss	Y	N		MUSCULOSKELETAL				Skin Cancer	Y	N	
GENETIC/BIRTH				Osteoarthritis	Y	N		Stomach Cancer	Y	N	
Birth Defects	Y	N		Osteoporosis	Y	N		Cancer – Other	Y	N	
GENITOURINARY				Other Inflammatory Connective D/O	Y	N		RESPIRATORY			
Endometriosis	Y	N		Rheumatoid Arthritis	Y	N		Asthma	Y	N	
Polycystic Kidney Disease	Y	N		Rheumatologic Disorder	Y	N		Pulmonary Embolism	Y	N	
Polycystic Ovary Disease	Y	N		Systemic Lupus	Y	N		Respiratory Disorder	Y	N	
Toxemia Of Pregnancy	Y	N						Tuberculosis	Y	N	

Bronson Review of Systems

NAME:

Constitution		
Activity change	Y	N
Chills	Y	N
Fatigue	Y	N
Fever	Y	N

Head, Ear, Nose, Throat		
Neck pain	Y	N
Neck stiffness	Y	N
Hearing loss	Y	N
Dental problem	Y	N
Mouth sores	Y	N

Eyes		
Eye pain	Y	N
Visual disturbance	Y	N

Respiratory		
Shortness of breath	Y	N

Cardiovascular		
Chest pain	Y	N
Leg swelling	Y	N
Palpitations	Y	N

Gastrointestinal		
Abdominal pain	Y	N
Constipation	Y	N
Diarrhea	Y	N
Vomiting	Y	N

Endocrine		
Increased appetite	Y	N
Increased urination	Y	N

Urinary		
Difficulty urinating	Y	N

DOB:

Muscular		
Joint pain	Y	N
Back pain	Y	N
Gait problem	Y	N
Joint swelling	Y	N
Muscle pain	Y	N

Skin		
Color change	Y	N
Rash	Y	N
Wound	Y	N

Allergies/Immune System		
Environmental allergies	Y	N
Immunocompromised	Y	N

Neurological		
Light-headedness	Y	N
Numbness	Y	N
Seizures	Y	N
Weakness	Y	N

Blood		
Bruises/bleeds easily	Y	N

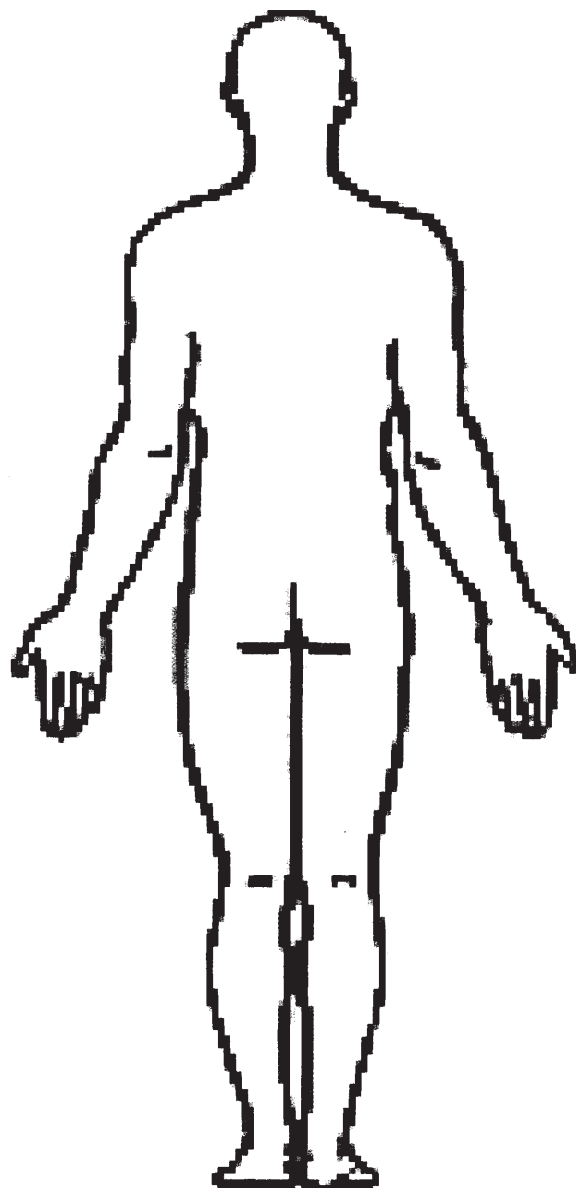
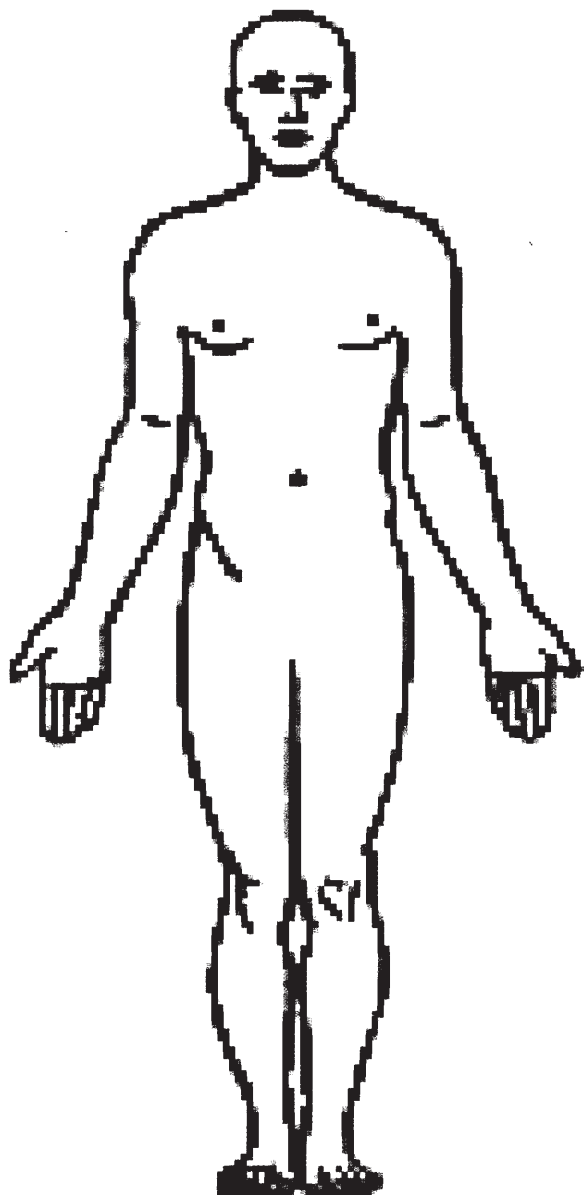
Psychiatric		
Confusion	Y	N
Sleep disturbance	Y	N

Abuse/Neglect		
Are you being physically, mentally, or sexually threatened?	Y	N
Do you feel safe going home?	Y	N
Do you feel adequately cared for?	Y	N

PATIENT NAME: _____

DATE OF BIRTH: _____

TODAYS DATE: _____



Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas or radiation. Include all affected areas.

NUMBNESS = = = = =

BURNING XXXXX

PINS & NEEDLES 00000

STABBING /////

