Advanced
Internal Medicine

Welcome to Advanced Internal Medicine! We are dedicated to optimizing the quality of healthcare through an integrative approach to health and wellness. We include both conventional and complementary treatments for general health, healing, and wellbeing. Our goal is to model and advance a standard of health care. This goal is achieved through our core values. We do our best at the clinic, so you live a full and healthy life.

Here at AIM, we have a full staff to help with treatment of our patients. This includes but is not limited to Dr. Christopher Alvarado, DO and Julie Alvarado, NP.

Our providers here at AIM are serious about your care and trained in alternative ways to treat chronic pain. That being said, we won't prescribe or continue prescribing any controlled substances. If you are in need of coming off of a controlled substance, we are more than happy to help you in your transition to something that will better your health.

Want to know a little about what we treat here at AIM? Beyond primary care we offer osteopathic manipulation, photobiomodulation and so much more. To dive a little deeper, osteopathic manipulation can be the fastest way to pain relief from musculoskeletal injuries. With photobiomodulation (PBMT) we offer targeted, transcranial, and systemic PBMT to help treat chronic or acute pain and memory issues. If you would like to learn more about any of these treatments, we can schedule an appointment to see if they would be a good fit for you. Looking to learn more about our practice? Visit our website at www.aim4healthmichigan.com. For updates and notices follow us on Facebook at Advanced Internal Medicine. Once you become a patient here at AIM, we will email you a link for our patient portal!

Please fill out all new patient forms and return to the receptionist. Once we receive your records, we will call you to schedule your new patient appointment. This appointment is for us to get to know you and for you to get to know us. We can’t wait to get started with your care!

Welcome to Advanced Internal Medicine

Your Patient-Centered Medical Home!

As we build your Medical Home you will notice some changes in the way we provide care, but many things will stay the same.

You may notice that:

- We ask what your goal is, or what you want to do to improve your health
- We ask you to help us plan your care, and to let us know if you think you can follow the plan
- The care team members are doing more and/or different parts of the care
- We remind you when tests are due so that you can receive the best quality care
- We may ask you to have blood tests done before your visit so that the doctor has the results at your visit
- We are exploring methods to care for you better; including ways to help you care for yourself.

We trust you, our patient, to:

- Tell us what you know about your health and illnesses
- Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications you are taking and ask for a refill at your office visit when you need one
- **Let us know when you see other doctors and what medications they put you on or change**
- **Ask other doctors to send us a report about your care when you see them**
- Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists.
- Learn about wellness and how to prevent disease
- Learn about your insurance so you know what it covers
- Keep your appointments as scheduled, or call and let us know when you cannot
- Give us feedback so we can improve our services (We may survey you in the future to understand this better.)

We will continue to:

- Provide you with a care team who will know you and your family
- Respect you as an individual-we will not make judgments based on race, religion, sex, age, disability, etc.
- Give care that meets your needs and fits with your goals and values
- Have a doctor on call 24 hours a day and 7 days a week
- Take care of short illness, long term disease and give advice to help you stay healthy
- To improve your care we are using technology-like our Electronic Health Record and we will strive to continuously improve

AVAILABLE COMMUNITY SERVICES

NEED HELP? DIAL 211 FROM ANY PHONE AND YOU WILL BE CONNECTED WITH A REFERRAL HOTLINE THAT CAN CONNECT YOU WITH NON-PROFIT AGENCIES IN THE AREA THAT CAN HELP WITH HUMAN, HEALTH AND SOCIAL NEEDS (I.E., UTILITIES, HOUSING, HEALTH INSURANCE, FOOD, DIAPERS, ETC.)

A LISTING OF THE AREA RESOURCES CAN ALSO BE FOUND ON THE AUNT BERTHA WEBSITE: https://www.findhelp.org

PLEASE ASK OUR STAFF FOR INFORMATION PERTAINING TO YOUR SPECIFIC NEEDS.

A Patient-Centered Medical Home (PCMH) is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

URGENT CARE

We strive to accommodate patients who need more urgent care. Please call us to see if we can see you or guide your care. Often we might guide you to care that serves you well. Emergency care is safer if we can guide the Emergency Department about your health situation.

Lansing Urgent Care - Frandor	Sparrow Urgent Care
505 N Clippert St	2682 E. Grand River
Lansing, MI 48912	East Lansing, MI 48532
(517) 999-2273	(517) 333-6562
Hours: Open 24 hours	Hours: Open 24 hours

LAB TEST RESULTS

Please try to use Sparrow or McLaren laboratories and other test facilities we use regularly to ensure better communication. We strive to get test results to patients. Please call the office to schedule a follow up appointment for your results.

Comprehensive Quality of Care

Please be aware, in the course of providing your care, your health care information may be shared among other Providers involved in your care, as appropriate.

PRACTICE HOURS

Monday: 8:00am – 5:00pm
Tuesday: 8:00am – 5:00pm
Wednesday: 8:00am – 5:00pm
Thursday: 8:00am – 5:00pm
Friday: 8:00am – 12:00pm
Saturday/Sunday: Closed

Christopher Alvarado, DO
2720 Pleasant Grove Road
Lansing, MI 48910
Phone: 517-575-9614
www.aim4healthmichigan.com

Advanced
Internal Medicine

Patient Demographic Form

***Name (First, Middle, Last):** _____ **Preferred Name:** _____

***Address:** _____

City**: _____State:** _____***Zip Code:** _____

Home Phone Number: _____ Cell Phone Number: _____

***Date of Birth:** _____ Social Security Number: _____

***Birth Sex:** ☐ Male ☐ Female ***Are you a legal US Citize**n: ☐ Yes ☐ No **Active Visa:** ☐ Yes ☐ No ☐ N/A

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual

☐ Other (please describe): _____ ☐ Choose not to Disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender (Female-to-Male) ☐ Transgender (Male-to-Female)

☐ Other (please specify): _____ ☐ Choose not to Disclose

***Email:** _____ ☐ I do not want one on file

Emergency Contact

***Name:** _____ **Relationship:** _____ **Phone:** _____

***Address:** _____

City:** _____State:** _____ ***Zip Code:** _____

☐ I choose not to provide an emergency contact and acknowledge that in case of emergency 911 will be called for me.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Is English your first language? ☐Yes ☐ No If not, what language? _____ If no, do you require a translator? ☐ Yes ☐ No

Which racial category do you most closely identify with? ☐ African American ☐ Asian

☐ Caucasian ☐ Mexican American Indian ☐ Other (Please specify): _____

What is your ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

***Pharmacy Name:** _____

Address: _____ Phone number: _____

***Patient Signature**: _____ Date: _____

Advanced
Internal Medicine

Patient Preferences for Verbal Communication of Protected Health Information

The following individuals are given permission to receive verbal information as indicated. **Please note the below named individuals may not access, request, or receive copies of your medical records without an Authorization for Release of Medical Records signed by you.** The intention of this form is to distinguish who we may talk to about your medical information only.

Name	Relationship	Phone number	Type of Information (All, Appointment info, test results, etc.)

☐ Yes	☐ No	May we leave a message on your voicemail regarding test results or medical advice?
☐ Yes	☐ No	May we leave information regarding an upcoming appointment or a request for you to call the office with another individual in your household? If yes, please indicate the individuals with whom we may leave such a message. ☐ Spouse ☐ Other _____
☐ Yes	☐ No	May we send written correspondence in a sealed envelope to your home address? If not, please indicate an alternate address where we may send confidential communications: _____

Policies and Limitations on Alternate Means of Communication:

- We are required to accommodate "reasonable" requests for communication with you by alternate means. We may deny the request if we determine that it is unreasonable.
- You agree that the security and confidentiality of the confidential information sent via alternate methods is your responsibility alone, and neither the physician nor the practice is responsible for any inadvertent disclosures that may occur as a result of fulfilling the request.

Print Patient Name: _____ Patient DOB: _____

Patient Signature: _____ Date: _____

Print Guardian Name: _____

Advanced
Internal Medicine

☐ I am a self-pay patient

Insurance Information

***Patient Name:** _____ **Date of Birth:** _____

Primary Insurance Name: _____

Mailing Claims Address (on back of card):_____

City: _____ State: _____ Zip Code: _____

Medical Claims Phone Number (on back of card): _____

Subscriber/Enrollee ID/Policy #: _____ Group #: _____

Subscriber Name (Name as written on card):_____

Relationship to Subscriber: ☐Self ☐Spouse ☐Natural Child ☐Stepchild ☐Foster Child

☐Other (please specify): _____

Subscriber Date of Birth: _____ Office Visit Copay: _____

Secondary Insurance Name: _____

Mailing Claims Address (on back of card): _____

City: _____ State: _____ Zip Code: _____

Medical Claims Phone Number (on back of card): _____

Subscriber/Enrollee ID/Policy #: _____ Group #: _____

Subscriber Name (Name as written on card): _____

Relationship to Subscriber: ☐Self ☐Spouse ☐Natural Child ☐Stepchild ☐Foster Child

☐Other (please specify): _____

Subscriber Date of Birth: _____ Office Visit Copay: _____

Tertiary Insurance Name: _____

Mailing Claims Address (on back of card): _____

City: _____ State: _____ Zip Code: _____

Medical Claims Phone Number (on back of card): _____

Subscriber/Enrollee ID/Policy #: _____ Group #: _____

Subscriber Name (Name as written on card): _____

Relationship to Subscriber: ☐Self ☐Spouse ☐Natural Child ☐Stepchild ☐Foster Child

☐Other (please specify): _____

Subscriber Date of Birth: _____ Office Visit Copay: _____

Patient Signature: _____ Date: _____

Advanced Internal Medicine
Christopher Alvarado, DO - Julie Alvarado, NP
2720 Pleasant Grove Rd
Lansing, MI 48910
Phone: 517-575-9614, Fax: 877-370-2381

Authorization for Use or Disclosure of Information

***Patient Name:** _____ Maiden/Other Name: _____

***D.O.B.**_____/_____/_____ ***Phone Number:** _____

***Patient Address:** _____

Street City State Zip

I authorize _____ to release all information
Previous Doctor's Practice Name and Phone Number

contained in the records which may include information regarding drug and/or alcohol treatment, psychological records, HIV/AIDS and other sexually transmitted diseases to be released to **Advanced Internal Medicine PLLC**.

_____

***Please send:**

- o Entire Medical Record
- o Medical records from (dates) _____ to _____
- o Other (specify): _____

_____

I understand that I have the right to revoke this authorization at any time by submitting a written notification. I consent to the release of the records as mentioned above.

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient

_____
Printed Name of Guardian (if applicable)

Advanced
Internal Medicine

Single Signature Consent

Initial next to the following:

_____ 1) HIPAA Privacy Notice:

I have been offered/I have read and understand Advanced Internal Medicine's HIPAA Privacy Notice.

_____ 2) Financial Policy:

I have been offered/I have read, understand, and agree to Advanced Internal Medicine's Financial Policy.

_____ 3) Assignment of Benefits/Release of Information for Insurance Purposes:

I authorize Advanced Internal Medicine to release to any third-party payer, or it's representative, including Medicare, Medicaid, Champs, Blue Cross/Blue Shield, Commercial Health Insurers, automobile no fault insurers, workers' disability compensation insurers, employers' health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment of my claims, or as required by law, such information from my medical record as is necessary to receive reimbursement for services rendered by Advanced Internal Medicine, including alcohol and drug abuse records protected under the regulation in 42 CFR, Part 2, if any, and social services, psychological services or psychiatric services.

_____ 4) General Consent to Treatment:

- I voluntarily request, consent to, and authorize all medical care, including physical examination and screening diagnostic procedures, drug administration, therapeutic treatments, including drug and alcohol screening as deemed necessary in the judgment of my Advanced Internal Medicine provider(s). I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me with respect to the results of the care and treatment that I receive.

_____ 5) Consent to Obtain Patient Medication History:

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ 6) Consent to Patient Communication;

I authorize Advanced Internal Medicine to contact me regarding my medical care, appointments, billing, and other healthcare-related information via the following methods: email, phone call, text message (SMS). I understand that these forms of communication may not be fully secure and that there is some risk that my protected health information (PHI) could be accessed by unauthorized individuals. I accept this risk and consent to receiving communications through these methods.

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Guardian Name (if minor): _____

Advanced
Internal Medicine

Health Questionnaire

Patient Name: _____ **Date of Birth:** _____

CURRENT PROBLEM/DIAGNOSIS (what brings you into the office today):

_____
_____
_____

CURRENT MEDICATIONS/SUPPLEMENTS: ☐ I am not taking **any** medications.

MEDICATION NAME	DOSAGE	FREQUENCY

PAST MEDICAL PROBLEMS/DIAGNOSIS: ☐ I am healthy and do not have **any** medical problems.

PREVIOUS DIAGNOSIS	Is this a current medical problem? (Y/N)

ALLERGIES: ☐ I do not have **any** allergies/medication allergies

ALLERGY/MEDICATION ALLERGY	TYPE OF REACTION	CRITICALITY (High/Low)

PAST SURGICAL HISTORY: ☐ I have not had **any** surgeries

DATE	PROCEDURE

HOSPITALIZATIONS: ☐ I have not had **any** hospitalizations

Separate from the surgeries above.

DATE	FACILITY	REASON

FAMILY HISTORY: ☐ I do not have **any** knowledge of my family history

Please tell us about medical problems in your **blood** relatives. Fill out the chart below by completing all the appropriate boxes that apply to each relative. For medical history please place an "X" in the appropriate boxes.

Family Member	**Status (Alive/ Deceased/Unknown)**	**Year of Birth**	**Type 2 Diabetes**	**High Blood Pressure**	**Heart Disease**	**High Cholesterol**	**Cancer (please specify)**	**Mental Health Disorder**	**Other (please specify)**
Father									
Mother									
Paternal Grand Father									
Paternal Grand Mother									
Maternal Grand Father									
Maternal Grand Mother									
Brother									
Sister									
Son									
Daughter									

Additional Family Information: In columns 2 through 4, circle the correct response. In column 5, list any medical problems if applicable.

	Gender	Deceased	Healthy	Medical Problems
Sibling	M F	Yes No	Yes No	
Sibling	M F	Yes No	Yes No	
Sibling	M F	Yes No	Yes No	
Sibling	M F	Yes No	Yes No	
Child	M F	Yes No	Yes No	
Child	M F	Yes No	Yes No	
Child	M F	Yes No	Yes No	
Child	M F	Yes No	Yes No	

SOCIAL HISTORY:

Tobacco use:

☐ Current smoker ☐ Former smoker ☐ Nonsmoker

If current smoker, when did you start: _____

How many cigarettes do you smoke a day: _____

Are you interested in quitting: _____

Do you use tobacco in other forms: ☐ Yes ☐ No If yes, please describe: _____

Drugs/alcohol use:

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No

Do you smoke marijuana? ☐ Yes ☐ No

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If yes, answer the following:

- How often have you had a drink containing alcohol?
  ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 or more times a week
- How many drinks did you have? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
- How often did you have 6 or more drinks on one occasion?
  ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine use:

Did you have a drink containing caffeine in the past day? ☐ Yes ☐ No

If yes, answer the following:

- How many cups per day?
  ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ More than 4
- What type of drink containing caffeine are you consuming? _____

Sexual history:

Have you had sexual intercourse in the past 12 months? ☐ Yes ☐ No

- If yes, was contraceptive or protection used? ☐ Yes ☐ No

Have you ever had a Sexually Transmitted Disease? ☐ Yes ☐ No

- If yes, please specify ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Herpes ☐ Other _____

Would you like to be screened for an STD? ☐ Yes ☐ No

Are you a victim of sexual abuse? ☐ No ☐ Previous history ☐ Yes, ongoing/present

Household:

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with significant other

Number of adults in the household: _____

Number of children in the household: _____

Practiced religion: _____

Level of education:

☐ High school – not graduated ☐ High School Diploma ☐ Some college ☐ Undergrad Degree

☐ Professional schools/Masters/PhD

Miscellaneous:

How often do you exercise?

☐ Daily ☐ Weekly ☐ Twice a week ☐ 4-5 times a week ☐ Never

How long do you exercise for?

☐ less than 30 minutes ☐ 30-60 minutes ☐ 1-2 hours

Do you follow a healthy diet? ☐ Yes ☐ No

Would you like information on how to follow a healthy diet? ☐ Yes ☐ No

Do you follow any of the following diet plans/restrictions?

☐ Diabetic ☐ Low sodium ☐ Low fat/low cholesterol ☐ Calorie Restriction ☐ Fluid Restriction

What is your occupation? _____

Are you retired? ☐ Yes ☐ No

Are you unemployed? ☐ Yes ☐ No

Are you unable to work/require disability paperwork? ☐ Yes ☐ No

Are you a current victim of Domestic Violence? ☐ Yes ☐ No

Are you in need of current help/recourses? ☐ Yes ☐ No

Are you a previous victim/survivor? ☐ Yes ☐ No

Female Menstrual History:

Age of first menstrual cycle: _____

Birth Control type: _____

Number of:

Children: _____

Pregnancies: _____

Miscarriages: _____

Live Births: _____

Stillbirths: _____

Advanced
Internal Medicine

AIM Previous Preventative Screenings

Mammogram

☐ I have never had a mammogram
Date of last scan: _____
Location of last scan + location address:
_____
_____
Result: _____

Pap Smear/Pelvic Exam

☐ I have never had a pap/pelvic exam
Date of last exam: _____
Location of last exam + location address + Name of physician:
_____
_____
Result: _____

Colonoscopy/Cologuard

☐ I have never had a colonoscopy/cologuard
Date of last test: _____
Location of last test + location address:
_____
_____
Result: _____

Bone Density Scan (DEXA)

☐ I have never had a DEXA
Date of last scan: _____
Location of last scan + location address:
_____
_____
Result: _____

Sleep Study

☐ I have never had a sleep study
Date of last scan: _____
Location of last scan + location address:
_____
_____
Result: _____

Labs

Date of last labs: _____ Lab Name: _____