

Covenant Building
2919 East Wilder Rd.
Suite 220
Bay City, MI 48706
Phone: (989) 894-8400

Saginaw Bay Dermatology New Patient Medical History

Saginaw Bay Dermatology
106 East Main St.
Sebewaing, MI 48759
Phone: (989) 883-3800
Fax: (989) 883-9131

Please answer all questions and bring this with you on the day of your appointment. If you provide your email address you may also have appointment and laboratory reminders sent to you via email.

Name: _____

Address: _____

City: _____ **State:** _____ **Zipcode:** _____

Phone (home): _____ **Phone (work/other):** _____

Email Address: _____ **Birthdate:** _____ **Gender:** _____

Emergency Contact – Must live in a separate residence or have a different phone number.

Name: _____ **Phone Number (Home):** _____

Relationship: _____ **Phone Number (Work):** _____

Insurance Information (if other than yourself) – Please bring your insurance cards with you.

All of the information below is required to properly bill your insurance company. If you do not provide all of the information requested, including the subscriber social security numbers, you will be billed for your visit.

Primary Insurance: _____ **Secondary Insurance:** _____

Subscriber Name: _____ **Subscriber Name:** _____

Subscriber Birth Date: _____ **Subscriber Birth Date:** _____

Subscriber SSN: _____ **Subscriber SSN:** _____

Office Visit Copay: _____ **** Your co-pay is due the day of your appointment ****

Referring / Family Physician

If your insurance is an HMO, then you require a referral from your family physician. If you do not have the required referral, you will have to pay for your visit (at the time of your visit) or you will not be seen.

Has your family doctor approved a referral? **YES** **NO**

Family Physician: _____ **Phone Number:** _____

Referring Physician: _____ **Phone Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Laboratory (if you need to use a specific one)

Lab Name: _____

NAME: _____

Birth Date: _____

REASON YOU ARE HERE: _____

MEDICATION HISTORY- List all medications that you currently take. *Include drugs like, Motrin, Tylenol, Vitamins, herbals, etc. Please bring all your medicines to your visit.*

Drug	Dose	Reason?	Drug	Dose	Reason?

MEDICATION ALLERGIES: NO YES - list medication allergies below

Medication	Type of Reaction	Medication	Type of Reaction

PAST MEDICAL HISTORY – Check only those that apply

ALLERGY/IMMUNO	CARDIO-VASCULAR	SKIN	PSYCHIATRIC
food allergy <input type="checkbox"/>	high cholesterol <input type="checkbox"/>	acne <input type="checkbox"/>	anxiety <input type="checkbox"/>
hay fever <input type="checkbox"/>	high triglycerides <input type="checkbox"/>	eczema <input type="checkbox"/>	depression <input type="checkbox"/>
lupus <input type="checkbox"/>	hypertension <input type="checkbox"/>	herpes <input type="checkbox"/>	NEUROLOGIC
rheumatoid arthritis <input type="checkbox"/>	heart attack <input type="checkbox"/>	keloids <input type="checkbox"/>	stroke <input type="checkbox"/>
scleroderma <input type="checkbox"/>	blood clots / DVT <input type="checkbox"/>	melanoma <input type="checkbox"/>	dementia <input type="checkbox"/>
vasculitis <input type="checkbox"/>	GI/GU	psoriasis <input type="checkbox"/>	MUSCULO-SKEL
EYES/NOSE	hemorrhoids <input type="checkbox"/>	skin cancers <input type="checkbox"/>	arthritis <input type="checkbox"/>
cataracts <input type="checkbox"/>	hiatal hernia <input type="checkbox"/>	warts <input type="checkbox"/>	Fractures <input type="checkbox"/>
glaucoma <input type="checkbox"/>	hepatitis <input type="checkbox"/>	ulcers <input type="checkbox"/>	ENDOCRINE
deafness <input type="checkbox"/>	stomach ulcers <input type="checkbox"/>	BLOOD	diabetes <input type="checkbox"/>
PULMONARY	Renal failure / dialysis <input type="checkbox"/>	anemia <input type="checkbox"/>	hypothyroid <input type="checkbox"/>
asthma <input type="checkbox"/>	kidney stones <input type="checkbox"/>	transfusions <input type="checkbox"/>	Hyperthyroid <input type="checkbox"/>
emphysema <input type="checkbox"/>	OTHER		
TB <input type="checkbox"/>			

SOCIAL HISTORY

Do you smoke? **No** **Yes** _____ packs/day for _____ years

Do you drink alcohol? **No** **Yes** _____ drinks/day

Do you use recreational drugs? **No** **Yes** ___ Injectable ___ Oral ___ Inhaled

Have you ever had an STD? **No** **Yes** (sexually transmitted disease)

Do you work? **No** **Yes** Occupation: _____

PAST SURGICAL HISTORY – Check all that apply

SURGERY	YES	NO	WHEN
CABG (Bypass)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Repair	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			_____

SURGERY	YES	NO	WHEN
Hip replacement - Right	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip replacement - Left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee replacement - Right	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee replacement – Left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iliostomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colectomy including partial	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			_____

Do you need antibiotics before procedures? **YES** **NO**

FAMILY HISTORY – Check all that apply

DISEASE	Father	G. Father	G. Mother	Mother	G. Father	G. Mother	Sister	Brother
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DISEASE	Father	G. Father	G. Mother	Mother	G. Father	G. Mother	Sister	Brother
Basal Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYSTEMS REVIEW – Check all that apply

GENERAL

appetite change
 chills
 dizziness
 excess thirst
 fatigue
 fever
 night sweats
 nausea / vomiting
 weight change

EYES

dry eyes
 light sensitive
 yellow eyes

ENT

bleeding gums
 dry mouth
 mouth ulcers
 sinus drainage

CARDIO-VASCULAR

chest pain/tight
 heart murmur
 leg swelling
 palpitations

GI

Black/ bloody stools
 constipation
 diarrhea
 heartburn
 stomach pain
 trouble swallowing

GU

blood in urine
 discharge
 painful urination

ENDOCRINE

abnormal hair growth
 abnormal hair loss
 flushing
 menstrual problems

MUSC-SKEL

back pain
 joint pains
 joint swelling
 leg cramps

NEUROLOGIC

blackouts
 headaches
 Numbness

PSYCHIATRIC

memory problems
 panic attacks
 suicide thoughts
 suicide attempt

PULMONARY

shortness of breath
 wheezing

OTHERS

x-ray therapy
 chemotherapy

ALLERGY/IMMUNO

watery eyes
 Sneezing

HEMATOLOGIC

bleeding tendencies
 easy bruising
 swollen lymph nodes

SKIN

blisters
 itching
 lesions/growths
 nail changes
 pigment loss
 sun sensitivity
 changing moles

NOTICE OF PRIVACY PRACTICES

BRENT M. BOYCE, M.D., P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

All patient care is overseen and supervised by an attending physician and provided by a team of health care professionals. Nurses and medical assistants may participate in examinations or procedures and in the care of patients.

This Notice applies to information and records regarding your health care maintained by Brent M. Boyce, M.D., P.C.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

Brent M. Boyce, M.D., P.C. is committed to protecting your medical information. This notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- make sure that your medical information is protected;
- give you this Notice describing our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures we will describe them and give some examples. Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. BRENT M. BOYCE, M.D., P.C. abides by all applicable state and federal laws related to the protection of this information. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We also may disclose medical information about you to people who may be involved in your continuing medical care after such as other health care providers, transport companies, community agencies and family members.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at BRENT M. BOYCE, M.D., P.C. or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about surgery you received at BRENT M. BOYCE, M.D., P.C. so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for BRENT M. BOYCE, M.D., P.C. operations. These uses and disclosures are made for quality of care and medical staff activities. Your medical information may also be used or disclosed to comply with law and

regulation, for contractual obligations, patients' claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of BRENT M. BOYCE, M.D., P.C. to another entity, underwriting and other insurance activities and to operate the health system. For example, we may review medical information to find ways to improve treatment and services to our patients. We may also disclose information to doctors, nurses, technicians, medical and other students, and other health system personnel for performance improvement and educational purposes.

Appointment Reminders. We may contact you to remind you that you have an appointment at BRENT M. BOYCE, M.D., P.C..

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your general condition and that you are in the hospital.

As Required By Law. We will disclose medical information about you when required to do so by federal or state law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Military and Veterans. If you are or were a member of the armed forces, we may release medical information about you to military command authorities as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

Workers' Compensation. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Public Health Disclosures. We may disclose medical information about you for public health purposes. These purposes generally include the following:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- reporting to the employer findings concerning a work-related illness or injury or workplace-related medical surveillance;
- notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

Health Oversight Activities. We may disclose medical information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Legal Proceedings. We may disclose medical information to courts, attorneys and court employees in the course of conservatorship and certain other judicial or administrative proceedings.

Lawsuits and Other Legal Actions. In connection with lawsuits or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death suspected to be the result of criminal conduct;
- About criminal conduct at BRENT M. BOYCE, M.D., P.C.; and
- In case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Your medical information is the property of BRENT M. BOYCE, M.D., P.C.. You have the following rights, however, regarding medical information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or receive a copy of your medical information.

To inspect and/or to receive a copy of your medical information, you must submit your request in writing to Brent M. Boyce, M.D., P.C.. If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by BRENT M. BOYCE, M.D., P.C. will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for BRENT M. BOYCE, M.D., P.C..

Amendment. To request an amendment, your request must be made in writing and submitted to Brent M. Boyce, M.D., P.C.. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by BRENT M. BOYCE, M.D., P.C.;
- Is not part of the medical information kept by or for BRENT M. BOYCE, M.D., P.C.;
- Is not part of the information which you would be permitted to inspect and copy; or

- Is accurate and complete in the record.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to Brent M. Boyce, M.D., P.C.. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

Right to an Accounting of Disclosures. You have the right to receive a list of the disclosures we have made of your medical information.

To request this accounting of disclosures, you must submit your request in writing to Brent M. Boyce, M.D., P.C.. Your request must state a time period that may not be longer than the six previous years and may not include dates before September 23, 2003. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had.

To request a restriction, you must make your request in writing to Brent M. Boyce, M.D., P.C.. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. *We are not required to agree to your request.* If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice shall be available at all offices of BRENT M. BOYCE, M.D., P.C., or you may obtain a copy at our website, <http://www.saginawbayderm.com>.

CHANGES TO BRENT M. BOYCE, M.D., P.C. PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change BRENT M. BOYCE, M.D., P.C. privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at BRENT M. BOYCE, M.D., P.C.. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact Brent M. Boyce, M.D., P.C., telephone number 989-894-8400. If you believe your privacy rights have been violated, you may file a complaint with BRENT M. BOYCE, M.D., P.C.. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

Saginaw Bay Dermatology

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient

Interpreter (if applicable)

Pursuant to the Notice of Privacy Practices I hereby authorize release of my medical information to the below named individuals. I know I may rescind this authorization at any time by providing a new, signed copy of the Privacy Practices Acknowledgement.

Authorized Person #1

Relationship

Authorized Person #2

Relationship

Witnessed by: