Saginaw Bay Dermatology

New Patient Medical History

Saginaw Bay Dermatology
4497 Sheffield Place
West of Euclid on North Union Road
Bay City, MI 48706
Phone: (989) 894-8400

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

Answer all questions and bring this with you on the day of your appointment - DO NOT MAIL.
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:_____**Work:**_____ **Cell:** _____
Email Address: _____ **DOB:** _____ **Gender:** _____
Race:_____ **Ethnicity:**_____ **Preferred Language:**_____
(e.g. Caucasian, Hispanic ect.)

INSURANCE INFORMATION - All of the information is required to properly bill your insurance company. If you do not provide the requested information, you may be billed for your visit. Please bring insurance cards and photo identification to EVERY appointment.

Primary Insurance: _____ **Secondary Insurance:**_____
Subscriber Name: _____ **Subscriber Name:**_____
Subscriber DOB: _____ **Subscriber DOB:**_____
Subscriber SSN: _____ **Subscriber SSN:**_____
Relationship to Patient: _____ **Relationship to Patient:**_____
Copay: _____ ****Your Copay is due the day of your appointment****

It is your responsibility to know your Copay!

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? **NO** **YES**

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

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

LABORATORY – Required or Preferred

Lab Name:_____

Name: _____ **DOB:** _____

Reason for visit: _____

MEDICATION HISTORY: List all medications that you currently take. Include drugs like, Motrin, Tylenol, vitamins, herbals, etc. Please bring all your medications to your visit.

Drug & Dose	Reason for Taking

ALLERGIES: NO YES - List medication allergies below.

Medication	Type of Reaction	Date

PAST MEDICAL HISTORY:

Allergy/Immune		**Cardio-Vascular**		**Skin**		**Psychiatric**	
Food Allergy	☐	High Cholesterol	☐	Acne	☐	Anxiety	☐
Hay Fever	☐	High Triglycerides	☐	Seborrheic Dermatitis	☐	Depression	☐
Lupus	☐	Hypertension	☐	Rosacea	☐	Neurologic	☐
Rheumatoid Arthritis	☐	Heart Attack	☐	Eczema	☐	Stroke	☐
Scleroderma	☐	Blood Clots/DVT	☐	Herpes	☐	Dementia	☐
Vasculitis	☐	**GI/GU**		Keloids	☐	**Musculo-Skel**	
Eyes/Nose		Hemorrhoids	☐	Melanoma	☐	Fractures	☐
Cataracts	☐	Hiatal Hernia	☐	Psoriasis	☐	Arthritis	☐
Glaucoma	☐	Hepatitis	☐	Skin Cancers	☐	**Endocrine**	
Deafness	☐	Stomach Ulcers	☐	Warts	☐	Diabetes	☐
Pulmonary		Renal Failure/Dialysis	☐	Ulcers	☐	Hypothyroid	☐
Asthma	☐	Kidney Stones	☐	Molluscum	☐	Hyperthyroid	☐
Emphysema	☐	Colitis	☐	**Blood**		Obesity	☐
TB	☐	Crohn's	☐	Anemia	☐		
				Transfusions	☐		
Cancer: ☐	Type:						

SOCIAL HISTORY:

Do you use tobacco? **No** **Yes** what type_____ how much _____ duration_____

Do you drink alcohol? **No** **Yes** _____ drinks per: day week month

Do you use recreational drugs? **No** **Yes**

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

Have you ever had an STD? **No** **Yes**

PAST SURGICAL HISTORY:

SURGERY	Yes	WHEN	SURGERY	Yes	WHEN
CABG (Bypass)	☐	_____	Hip replacement – R or L	☐	_____
Hysterectomy	☐	_____	Knee replacement – R or L	☐	_____
Gallbladder Surgery	☐	_____	Back Surgery	☐	_____
Appendectomy	☐	_____	Bowel Surgery	☐	_____
Heart Valve Repair	☐	_____	Tonsillectomy	☐	_____
Stent	☐	_____			
Any other Surgeries:					

ANTIBIOTIC PROPHYLAXIS REQUIRED (Do you need antibiotics before procedures)?: **NO** **YES**

FAMILY HISTORY:

Disease	Yes	Who in Family	Disease	Yes	Who in Family
Diabetes	☐		Basal Cell Skin Cancer	☐	
Hypertension	☐		Squamous Cell Skin Cancer	☐	
Heart Disease	☐		Melanoma	☐	
High Cholesterol	☐		Lupus	☐	
Arthritis	☐		Asthma	☐	
Cancer	☐		Eczema	☐	

SYSTEMS REVIEW:

General		Cardio-Vascular		Endocrine (cont.)		Allergy/Immune	
Appetite Change	☐	Chest Pain/Tightening	☐	Abnormal Hair Growth	☐	Watery Eyes	☐
Chills	☐	Heart Murmur	☐	Hair Loss	☐	Sneezing	☐
Dizziness	☐	Leg Swelling	☐	**Musculoskeletal**		**Hematologic**	
Excessive Thirst	☐	Leg Pain	☐	Back Pain	☐	Easy Bruising	☐
Fatigue	☐	Palpitations	☐	Joint Pain/Weakness	☐	Bleeding Tendencies	☐
Fever	☐	Varicose Veins	☐	Joint Stiffness	☐	Swollen Lymph Nodes	☐
Night Sweats	☐	**GI/GU**		Muscle Cramps/Weakness	☐	**Skin**	
Nausea/Vomiting	☐	Frequent Urination	☐	Cold Extremities	☐	Acne	☐
Weight Change	☐	Blood in Urine	☐	Difficulty Walking	☐	Rash/Itching	☐
Eyes		Incontinence	☐	**Neurologic**		Eczema	☐
Dry Eyes	☐	Kidney Stones	☐	Headaches	☐	Changing Moles	☐
Eye Disease	☐	Loss of Appetite	☐	Numbness/Tingling	☐	Growths/Lesions	☐
Blurred/Double Vision	☐	Diarrhea	☐	Blackouts	☐	Sun Sensitivity	☐
Light Sensitive	☐	Constipation	☐	**Psychiatric**		Infections/Wounds	☐
Yellow Eyes	☐	Blood in Stool	☐	Memory Problems	☐	Blisters/Abscesses	☐
ENT		Stomach Pain	☐	Nervousness	☐	Nail Changes	☐
Hearing Loss	☐	Heartburn	☐	Depression	☐	Pigmentation Changes	☐
Ringing in Ears	☐	Discharge	☐	Sleep Problems	☐	Flushing	☐
Sinus Problems	☐	**Endocrine**		Panic Attacks	☐	Excessive Sweating	☐
Nose Bleeds	☐	Hormone Problems	☐	Anxiety Disorders	☐	**Others**	
Mouth Ulcers	☐	Thyroid Disease	☐	**Pulmonary**		X-ray Therapy	☐
Bleeding Gums	☐	Excessive Thirst	☐	Frequent Coughing	☐	Chemotherapy	☐
Dry Throat/Mouth	☐	Abnormal Menstruation	☐	Shortness of Breath	☐		

OFFICE FINANCIAL POLICY

The following guidelines are provided so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

1. We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:
    - The annual deductibles, co-payments and for any charges for non-covered or cosmetic services*

    *You will be asked to sign an Advanced Notice of Liability Form (ABN) in the event that a service is provided which we know is not covered by Medicare.

2. If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment if received from your secondary/supplemental carrier within 60 days after we file a claim, **you will be sent a bill and will be responsible for the balance.**

Commercial Insurance (Participant):

1. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:
    - The annual deductibles, co-payments and for any charges for non-covered or cosmetic services

    In the event that you, as the patient, or we, as the providers, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

2. **It is your responsibility to arrange any needed referrals prior to the date of your appointment. If you do not have the necessary referral you will be given the option to pay for your visit (on the date of service) or you will not be seen.**

Commercial Insurance (Non-participant) or Non Insured:

3. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship or if you are not insured, please note the following:
    - Your entire balance is due at the time of service.

All Patients

If payment is not received after any portion of your balance becomes more than 90 days past due you may receive a *Final Notice* statement. Failure to pay the full balance owed after a *Final Notice* has been sent may result in legal action and/or you may be discharged from the practice.