

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

Saginaw Bay Dermatology

New Patient Medical History

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	<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"/>	Seborrheic Dermatitis	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Scleroderma	<input type="checkbox"/>	Blood Clots/DVT	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Dementia	<input type="checkbox"/>
Vasculitis	<input type="checkbox"/>	GI/GU		Keloids	<input type="checkbox"/>	Musculo-Skel	
Eyes/Nose		Hemorrhoids	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	Fractures	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Skin Cancers	<input type="checkbox"/>	Endocrine	
Deafness	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	Warts	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Pulmonary		Renal Failure/Dialysis	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Molluscum	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Blood		Obesity	<input type="checkbox"/>
TB	<input type="checkbox"/>	Crohn's	<input type="checkbox"/>	Anemia	<input type="checkbox"/>		
				Transfusions	<input type="checkbox"/>		
Cancer: <input type="checkbox"/>	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)	<input type="checkbox"/>	_____	Hip replacement – R or L	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	_____	Knee replacement – R or L	<input type="checkbox"/>	_____
Gallbladder Surgery	<input type="checkbox"/>	_____	Back Surgery	<input type="checkbox"/>	_____
Appendectomy	<input type="checkbox"/>	_____	Bowel Surgery	<input type="checkbox"/>	_____
Heart Valve Repair	<input type="checkbox"/>	_____	Tonsillectomy	<input type="checkbox"/>	_____
Stent	<input type="checkbox"/>	_____			
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	<input type="checkbox"/>		Basal Cell Skin Cancer	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>		Squamous Cell Skin Cancer	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>		Melanoma	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>		Lupus	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>		Eczema	<input type="checkbox"/>	

SYSTEMS REVIEW:

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

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 is 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.