WEST BLOOMFIELD
DERMATOLOGY AND MOHS SURGERY

NEW PATIENT FORMS

Date: _____

First Name: _____ Middle Initial: ____ Last Name: _____
Date of birth:_____ Gender: _____
Street Address: _____ City: _____
State:_____ Zip:_____
Preferred phone number: _____ (please circle type: home work mobile)

(If you would like to receive appointment reminders via text message at the above number, check box ☐)
please note phone number must be a mobile phone number to receive reminders via text message

Secondary phone number: _____ (please circle type: home work mobile)
E-mail address:_____

(If you would like to receive appointment reminders via email, check box ☐)

Occupation: _____

Emergency contact name and phone number: _____

Insurance

Primary Insurance
Subscriber name & date of birth (if other than self):
_____
Insurance Carrier: _____
ID: _____
Group: _____

Secondary Insurance (if applicable)
Subscriber name & date of birth (if other than self):
_____
Insurance Carrier: _____
ID: _____
Group: _____

Account Responsibility (if minor child)
Name of responsible party: _____
Relationship to patient: _____
Address: _____

CONSENT TO LEAVE MEDICAL INFORMATION ON VOICEMAIL

My signature authorizes Dr. Mohammadi, Dr. Sklar, Dr. Hwang, Dr. Shabeeb or their delegates to leave a message on my answering machine regarding my results or any other medical information pertaining to my medical care.

Signature: _____ Date:_____
Phone number to leave message: _____

INSURANCE AUTHORIZATION

I hereby authorize Dr. Mohammadi, Dr. Sklar, Dr. Hwang, and Dr. Shabeeb to provide my information to my insurance carriers concerning my treatment and hereby assign to the physicians all payments for all medical services rendered to me or my dependents. I understand I am responsible for any deductibles, co-pays, or amounts not covered by my insurance and that it is my responsibility to know my insurance coverage. If any unpaid balance is sent to a collection agency, I understand that I will be responsible for any charges insured from the collection agency.

Signature: _____ Date:_____

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Reason for your visit today: Please circle all that apply

Skin Check Change in mole Rash Wart Acne Botox Filler

Other (Please explain): _____

_____

Who referred you to this office (if applicable):_____

Medical History: Please circle yes or no for the following

Anxiety or depression	YES / NO	High cholesterol	YES / NO
Arthritis	YES / NO	History of hay fever	YES / NO
Asthma	YES / NO	History of hives	YES / NO
Atrial fibrillation	YES / NO	HIV / AIDS	YES / NO
Bleeding disorder	YES / NO	Inflammatory bowel disease	YES / NO
Cancer (type: _____)	YES / NO	Jaundice	YES / NO
Chronic obstructive lung disease	YES / NO	Kidney disease	YES / NO
Diabetes Mellitus	YES / NO	Liver disease	YES / NO
Eczema or Atopic Dermatitis	YES / NO	Psoriasis	YES / NO
Elevated blood pressure	YES / NO	Radiation therapy	YES / NO
Hearing loss	YES / NO	Rheumatologic Disease (Lupus, Raynaud's, Rheumatoid arthritis, psoriatic arthritis, etc.)	YES / NO
Heart disease	YES / NO	Stroke / TIA	YES / NO
Hepatitis	YES / NO	Thyroid condition	YES / NO

Skin History: Please circle and list all that apply

Personal history of skin cancer (please circle): Basal Cell / Squamous Cell / Melanoma

Family history of skin cancer: YES / NO List relatives:_____

History of tanning bed use: YES / NO

History of severe sunburns: YES / NO

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Past Surgeries: Please circle yes or no for the following

Kidney Transplant	YES / NO	Pacemaker	YES / NO
Skin Biopsy	YES / NO	Defibrillator	YES / NO

Joint replacement: YES / NO
Please specify if yes: _____
Other Surgeries (please list): _____
_____
_____

Personal History:

Artificial heart valve	YES / NO	Problems with bleeding	YES / NO
Blood thinners	YES / NO	Problems with healing	YES / NO
Immunosuppression	YES / NO	Problems with scarring	YES / NO
Premedication prior to procedures	YES / NO	Pregnancy or planning pregnancy	YES / NO
Rapid heart beat with epinephrine	YES / NO	MRSA	YES / NO

Social History:
Smoking status (circle one): Never Smoker / Former Smoker / Current Smoker

Alcohol use: How many glasses of alcohol do you drink per week? _____

Immunizations in the last year:
Influenza YES / NO
Pneumonia YES / NO
COVID YES / NO

Preferred Pharmacy:
Name: _____ Phone Number: _____
Address and/or crossroads: _____
_____

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Medications:

Name of Medication	Dosage	Frequency

Drug Allergies:

Adhesive YES / NO Lidocaine YES / NO Topical Antibiotics YES / NO

Please list any other allergies below:

_____

_____

_____

All medical and personal history is filled out to the best of my knowledge.

Signature: _____ Date:_____

(Parent/Guardian Signature if necessary)

Print name of parent/guardian if necessary: _____

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Financial Policy: Due to ongoing insurance policy changes, it is no longer an easy task to monitor each individual policy. Insurance companies offer many different types of health coverage. Most of the plans require the patient to pay a deductible, copay and/or coinsurance charges. The amount of your copay, coinsurance and deductible depends on your individual insurance policy. Ultimately, it is **YOUR responsibility to understand your individual coverage.** Therefore, we strongly encourage you to check with your insurance company prior to any office procedure.

Please be advised that all costs incurred during your office visit that are not paid by your insurance company will be your responsibility to pay.

Deductible

Most insurance plans require a patient to pay an annual deductible. The patient must pay their health care provider/s for services totaling the deductible amount *before* the insurance company will begin to pay. Your insurance company will not pay any charges until you have met your *current yearly deductible.*

Copay/Coinsurance

Many insurance plans require the patient to pay a percentage of their health care costs. This amount is your coinsurance and is payable to the health care provider. You may also have a set amount you pay at each visit; this amount is your copay. If a service is not covered by the insurance plan, by law, the patient is usually responsible for the full amount.

Please Note

The billing staff will charge you according to the information provided by your insurance company. When we receive payment, if your insurance company has determined you owe additional charges, *as required by law*, you will be billed. All outstanding balances must be paid *prior* to your next visit.

VERIFICATION OF CORRECT INFORMATION & NO SHOW POLICY ACKNOWLEDGEMENT I hereby attest that all information listed above has been reviewed by myself and is correct. I understand that I will be charged a fee of $25.00 for any no show appointments and appointments canceled with less than 24 hours notice.

Signature: _____ Date:_____
(Parent/Guardian Signature if necessary)

Print name of parent/guardian if necessary: _____

I agree to pay for all charges not covered by insurance; this includes copays, coinsurance and deductibles. I have read and understand the above information and agree to pay West Bloomfield Dermatology as stated above.

Signature: _____ Date:_____
(Parent/Guardian Signature if necessary)

Note and acknowledgement of privacy policy

Acknowledgement:
I acknowledge that I have received the Notice of Privacy Practice for West Bloomfield Dermatology

Signature: _____ Date:_____
(Parent/Guardian Signature if necessary)

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Authorization to release medical information to someone other than myself

I authorize Dr. Mohammadi, Dr. Sklar, Dr. Hwang, Dr. Shabeeb, Daniel Tomlinson, or their delegates to discuss all personal health information in my file with the following person(s):

(Please list name, relationship to patient, and contact phone number for authorized individual (s))

Signature/Date:
