beacon skin & surgeries DERMATOLOGY

□ 110 South Blvd. Suite 100, Rochester Hills, MI 48307 Ph 248-852-1900
□ 37595 W. Seven Mile Rd. Suite 240, Livonia, MI 48152 Ph 734-307-2400
□ 46591 Romeo Plank Rd Suite 205A, Macomb, MI 48044 Ph 586-368-3600
□ 44000 W 12 Mile Rd Suite 103, Novi, MI 48377 Ph 248-946-4787
□ 8338 Allen Rd, Suite 201, Allen Park, MI 48101 Ph 313-346-9900

INSTRUCTIONS: **PLEASE FILL OUT THE FOLLOWING FORMS COMPLETELY. IF A PAPER FORM, PLEASE MAIL BACK IN RETURN ENVELOPE OR FAX TO 248-852-1919 (Rochester, Livonia, Macomb, & Allen Park) or 248-716-5956 (Novi)**

Full Name:		Date of Birth:
Address:		City:
State:		Zip Code:
Gender:	Gender at Birth (if different):	Email Address:
**Cell Phone #: Home Phone #: **By providing your cell phone #, you agree to receive text messages from our office related to health care, billing or appointments. You are solely responsible for any message or date rates that may apply and can opt out at any time.		Emergency Contact Name: Emergency Contact Relation: Emergency Contact Phone #:
☐ Check this box if you authorize Beacon Skin & Surgeries to leave detailed messages, including test results, on your voicemail.		Preferred Pharmacy Name, Phone # and City:

Referring Physician:	Primary Care Physician:
Referring Physician Phone #:	Primary Care Physician Phone #:
Referring Physician Address:	Primary Care Physician Address:

Please list the name, phone number and fax of any doctors (besides the referring physician and primary care physician listed above) who should receive a note about today's visit: _____

Insurance Information: ☐ **Check this box if you have no insurance and will be self-pay.**

Primary Insurance:

Name of Insurance:	Policy Type:
Member ID #:	Group #:
Policy Holder Name (If not self):	Relationship To Policy Holder:
Policy Holder Gender:	Policy Holder DOB:

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Patient Name: _____ Patient DOB: _____

Secondary Insurance:

Name of Insurance:	Policy Type:
Member ID #:	Group #:
Policy Holder Name (If not self):	Relationship To Policy Holder:
Policy Holder Gender:	Policy Holder DOB:

If you were not referred by a physician listed above, who referred you to our office or how did you hear of us?
List here: _____

Past Medical History: Select any of the following medical conditions that you have currently:

Anxiety		Colon Cancer		Hay Fever/Nasal Allergies		Hypothyroidism		Radiation Treatment	
Arthritis		COPD		Hearing Loss		Inflammatory Bowel Disease		Seizures	
Asthma		Coronary Artery Disease		Hepatitis		Leukemia		Stroke	
Atrial Fibrillation (Irregular Heartbeat)		Depression		Hypertension		Lung Cancer		Other:_____ _____	
Bone Marrow Transplantation		Diabetes		HIV/AIDS		Lymphoma		None	
BPH (Benign Prostatic Hyperplasia)		End Stage Renal Disease		Hypercholesterolemia		Organ Transplant			
Breast Cancer		GERD (Esophageal Reflux)		Hyperthyroidism		Prostate Cancer			

Past Surgeries: Please list any prior surgeries or procedures (don't forget any heart surgery, joint replacements, skin surgeries, C-section, tubal ligation, or hysterectomy):
List here: _____

_____

Skin Disease History: Have you had any of the following skin conditions:

Acne		Blistering Sunburns		Melanoma		Psoriasis	
Actinic Keratosis		Eczema		Moles called Atypical or Dysplastic Moles / Nevi		Squamous Cell Skin Cancer	
Basal Cell Skin Cancer		Flaking or Itchy Scalp		Poison Ivy		Other: _____	

** If you have had Basal Cell, Squamous Cell or Melanoma skin cancer in the past, please list below the location on the body, how it was treated, when it was treated and who treated it.
List here: _____

_____

Do you wear sunscreen?	☐ YES (what SPF? (_____)	☐ NO
Do you tan in a tanning salon?	☐ YES	☐ NO

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Patient Name: _____ Patient DOB: _____

Allergies: **Are you allergic to any medication?** ☐ **YES** ☐ **NO**
If yes, please fill out below: I am allergic to:

☐ Latex ☐ Local Anesthesia ☐ Erythromycin ☐ Penicillin ☐ Cephalexin ☐ Tetracycline/Doxycycline

☐ Sulfa ☐ Other (including foods): _____

List the date or year that you had the reaction and what type of symptoms (i.e. rash, itching, hives, shortness of breath, nausea): _____

MEDICATIONS: **THIS IS VERY IMPORTANT**! Please list your medications and supplements, with the month and year that you began each medication. It is imperative that you fill this table out COMPLETELY and to the best of your ability. Don't forget over the counter products like Aspirin, Ibuprofen and Tylenol. Also, please write any medication you have stopped within the last 6 months.

Medication Name	Dosage	Frequency	Route (ex. Oral/IV)	Date Began	Date Ended

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Patient Name: _____ Patient DOB: _____

SOCIAL HISTORY & LIVING WILL

Do you have a living will? ☐ Yes ☐ No Please state who the surrogate is, if yes?
Do you smoke tobacco? ☐ Current Everyday Smoker ☐ Current Someday Smoker (tobacco) ☐ Current Someday Smoker (cigarettes) ☐ Cigar Smoker ☐ Former Smoker ☐ Never Smoker
Do you drink alcohol? ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

****

Female Patients Only (This applies to all females age 10 and older)

Are you pregnant?	Yes	No	If yes, explain:
Are you planning a pregnancy?	Yes	No	If yes, explain:
When is the date of your last menstrual cycle/period (enter date/year even if menopausal)?			
If you are avoiding pregnancy, what method are you using? (i.e. birth control pills, IUD, abstinence, Depo-Provera, condoms)			
Are you breast feeding / nursing	Yes	No	If yes, please list how long you plan to continue nursing:

****

Family History: Do you have a family history of Melanoma? ☐ No ☐ Yes; If yes, which relative**?**

Mother		Daughter		Nephew		Grandson	
Father		Son		Niece		Granddaughter	
Sister		Uncle		Grandmother		Other	
Brother		Aunt		Grandfather		None	

Do you have a family history of:
Heart attack ☐ No or ☐ Yes. If yes, please specify which family member: _____
Stroke ☐ No or ☐ Yes. If yes, please specify which family member: _____

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Patient Name: _____ Patient DOB: _____

General Questions:

	YES	NO	If yes, explain and provide dates:
Do you have a pacemaker?			
Do you have a defibrillator?			
Do you have artificial joints?			
Do you have an artificial heart valve?			
Do you take premedication or antibiotics prior to dentistry or procedures?			
Are you allergic to topical antibiotics? (ie antibiotic oinment)			
Are you on blood thinners?			
Do you have other bleeding problems?			
Do you get rapid heartbeat with epinephrine?			
Do you get yeast infections with antibiotics?			
Do you get GI upset with antibiotics?			
Are you allergic to lidocaine?			
Do you have anxiety (at doctor's office)?			
Do you have problems with healing?			
Do you have nausea or upset stomach?			
Do you have chest pain?			
Do you have a cough?			
Do you have a fever or chills?			
Do you have headaches?			
Do you have joint pains?			

Signature: _____ Date:_____

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PATIENT SPECIALIST PARTNERSHIP AGREEMENT

Our goal is to provide you with the best care possible. This can happen by using us as your Patient Centered Specialty Care doctor. We work with your Referring doctor who is your Patient Centered Medical Home to help you feel better. Below are some important things to remember:

PATIENTS Please:

- After our visit, go see your Referring doctor.
- Make and keep all appointments with our office and with your Referring doctor.
- If you must cancel an appointment, make another one right away.
- Ask questions until you know what you need to do when you leave our office.
- Follow the plan we talked about during your appointment.
- If you are not able to follow the plan for any reason, tell us right away so we can help you set up another plan so you get the best results.

SPECIALIST DOCTOR:

- We will ask you who your Referring doctor is. We will let him/her know about your care as soon as possible.
- We will talk with you about your health and what you need to do to take care of yourself.
- We will talk to you by phone and in the office to answer your questions.

If your Referring doctor tells us that we should continue to take care of a particular condition, the following will also happen:

- We will share information about your plan and goals with your Referring doctor as quickly as possible.
- We will give you information; help you to learn how to take care of yourself, and help you to set goals to improve your health.
- We will work with you to set up a plan to help you take care of your health along with your Referring doctor.