MARONE DERMATOLOGY

JUSTIN J. MARONE, D.O.
CLINICAL DERMATOLOGIST

1457 NORTH M-52, UNIT 1, STE. A
OWOSSO, MI 48867
P: (989) 725-8436 F: (989) 723-8164

New Patient Appointment Confirmation

_____ has an appointment on:

Mon. Tues. Wed. Thurs. Fri.

Date: _____ Time: _____ am/pm

My staff and I want to take a moment to welcome you to Marone Dermatology, the office of Dr. Justin J. Marone. Dr. Marone is a board certified dermatologist and a member of the American Osteopathic College of Dermatology, specializing in the treatment of skin conditions and disorders for people of all ages.

- Marone Dermatology is located at 1457 N. M-52 Unit 1 Suite A, Owosso, MI. Located between VG's Supermarket and PFCU and across the street from Greg & Lou's Restaurant.
- **Please fill out the attached new patient forms and bring with at the time of your first visit.**
- **Also, be sure to bring your insurance card(s) with you.**
- **We ask that you arrive at least 10 minutes early on your first visit to prepare your new patient file.**

If you have any questions please do not hesitate to contact our office.
We look forward to seeing you soon!

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PATIENT INTAKE INFORMATION

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Last Name:	First Name:	M.I.:

(Previously Known Name)	SS #:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Apt/Ste:	Home Phone:

City:	State:	Zip Code:	Cell Phone:

Occupation:	Employer Name:	Employer Phone:

INSURANCE INFORMATION
PLEASE BRING INSURANCE CARD(S) TO APPOINTMENT

Person Responsible for Bill:	Birth date:	Phone Number:

Address (*if different than the patient*):	SS #:

Primary Insurance Name:

Subscriber's Name:	Subscriber's SS #:	Birth Date:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Insurance *(if applicable):*	Subscriber's Name:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Marone Dermatology or insurance company to release any information required to process my claims. **I understand that it is my *(Patient/Responsible Party)* responsibility to check with my insurance carrier(s) to verify In-Network coverage.**

Patient/Guardian signature *Date*

(SEE BACK SIDE OF PAGE)

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicated that I have received/or reviewed a copy of my physician's (*Marone Dermatology*) Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

o **Patient or Responsible Party Signature** _____ **Date** ____/____/____

PAYMENT POLICY:

Medicare: We are a participating provider of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for any co-payment, as determined by insurance carrier. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed. If payments go into a collection status, patient will be charged a $35 fee. *Note: If you have recently joined (or changed) to Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.*

HMO, PPO, or other Managed Care patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay entire unpaid balance left after payment from your insurance. Balance will be billed to you regardless of the benefits and payment policies of your carrier.

o **Patient or Responsible Party Signature** _____ **Date** ____/____/____

*****MEDICARE PATIENTS ONLY*****

The office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

o **Signature as it appears on Medicare card** _____ **Date** ____/____/____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

o **Signature as it appears on Medicare card** _____ **Date** ____/____/____

Dermatology Medical History

Marone Dermatology - Dr. Justin J. Marone

Patient Name _____ **DOB** _____ **Date**_____

Reason for today's visit_____

Are you allergic to any medications? ( )YES ( )NO

If yes, list:_____

Have you ever had dental anesthesia (Novocain)? ( )YES ( ) NO If yes, did you have a bad reaction? ( )YES ( )NO

List any *(or provide a list of)* medications you are currently taking ***(incl. prescriptions, over-the-counter, vitamins, & herbs)***

_____

Please check *YES* or *NO* if you do or do not have any of the following:

Lungs:	**YES**	**NO**
Bronchitis:	( )	( )
Diabetes:	( )	( )
Emphysema:	( )	( )
Asthma:	( )	( )
Chronic Cough:	( )	( )
Morning Cough:	( )	( )
Shortness of Breath:	( )	( )
Wheezing:	( )	( )
Cardiovascular:	**YES**	**NO**
High Blood Pressure:	( )	( )
Chest Pain:	( )	( )
Heart Attack:	( )	( )
Heart Murmur:	( )	( )
Irregular Heartbeat:	( )	( )
Phlebitis:	( )	( )
Inflammation of Vein:	( )	( )
Blood Clots:	( )	( )

Other Systemic:	**YES**	**NO**
Excessive thirst/hunger:	( )	( )
Amputation:	( )	( )
Thyroid:	( )	( )
Kidney Disease:	( )	( )
Dialysis:	( )	( )
Bladder - Frequency/burning:	( )	( )
Gastrointestinal:		
Stomach absorptive disorder:	( )	( )
Nausea, vomiting, diarrhea:	( )	( )
when taking antibiotics:	( )	( )
Yeast Infection(s) when taking antibiotics:	( )	( )
Arthritis/Joint Deformity:	( )	( )
Arthralgia:	( )	( )
Limited motion:	( )	( )
Artificial Joint:	( )	( )
Convulsions, Epilepsy or Seizures:	( )	( )
Fainting:	( )	( )

List any other diseases/conditions:_____

List surgical procedures you have had in the last 6 months:_____

(Female Only)**Are you currently pregnant?**( ) YES ( )NO Due Date ___/___/___ **Are you nursing?** ( )YES ( ) NO

Skin: Have you ever had skin cancer? ( )YES ( ) NO If yes, what kind and when? _____.

Has anyone in your family had skin cancer? ( )YES ( ) NO Who/What kind _____.

Do you have a history of any specific skin diseases? ( )YES ( ) NO If yes, what kind?_____.

Do you have problems with healing? ( )YES ( ) NO. Do you develop keloids (scars) after surgery?( )YES ( ) NO

Do you bleed easily? ( )YES ( ) NO

Do you develop skin rashes to:( )Medications, ( ) Foods, ( ) Environment, ( ) Bandages/Adhesives, ( ) Topical Neosporin?

Social History: Do you drink alcohol? ( ) YES ( )NO If YES _____ drinks per day/week.
Do you use IV drugs? ( ) YES ( )NO If YES. What?_____ How often_____
Do you smoke? ( ) YES ( )NO If YES. How much?_____
Have you ever been exposed to HIV (AIDS)? ( ) YES ( )NO

What is your occupation?_____ Hobbies?

_____

_____ ___/___/___

_____ ___/___/____

Patient Signature *(or Parent/Guarantor Signature)* *Date* *Reviewed by: (Staff Use)* *Date*

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CONFIDENTIAL COMMUNICATIONS AUTHORIZATION

PATIENT NAME: _____

DATE OF BIRTH: _____/_____ /_____ DATE: _____/_____ /_____

I authorize the practice to leave a message on my answering machine/voicemail: **[ ]YES [ ]NO**

HOME PHONE: _____ CELL PHONE: _____

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

NAME OF PERSON: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

NAME OF PERSON: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

☐ Check here if you **DO NOT** authorize the release of protected health information to anyone other than patient/guarantor.

Patient/Guardian/Guarantor Signature: _____ Date:_____

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PREFERRED PHARMACY INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____/_____ /_____ DATE: _____/_____ /_____

Preferred Retail pharmacy:

NAME/LOCATION _____

TELEPHONE/FAX _____

Preferred Mail order pharmacy:

NAME/LOCATION _____

TELEPHONE/FAX _____

Rx Coverage Information: *(If different than Medical Insurance Card/Medicare-D Coverage)*

PLAN NAME/COMPANY_____

MEMBER NUMBER_____

Rx BIN/GROUP NUMBER_____

Patient/Guardian/Guarantor Signature: _____ Date:_____