STUTZ DERMATOLOGY
919 W. UNIVERSITY DR., SUITE 100, ROCHESTER MI 48307
PHONE: 248.651.9500 FAX: 248.651.3366

Health Questionnaire

Legal Name: _____ DOB: _____

Nickname: _____

Primary Care Physician: _____

Reason to be seen: _____

List all medications, over-the-counter and vitamins you currently take. (*List by Medication, Dosage, Frequency*)

Do you take antibiotic's before teeth cleaning? Yes_____ No _____

Are you pregnant, possibly pregnant, trying to get pregnant, or breast feeding? Yes_____ No_____

Please list all medications that you are allergic to. Even if you don't think they concern dermatology.

_____

Family history of skin problems? Yes_____ No_____ (if yes, please explain)

_____

Please check if you have problems with any of the following:

_____ Heart
_____ Liver
_____ Kidney
_____ Diabetes
_____ Seizures
_____ TB
_____ Breathing
_____ Digestion
_____ Arthritis
_____ Bleeding
_____ HIV
_____ Hepatitis
_____ High Blood Pressure
_____ Artificial Joints
_____ Psychiatric
_____ Thyroid
_____ Other _____

Cancer of: _____

Occupation: _____

We offer some cosmetic procedures. Please check if you are interested in obtaining additional information.

_____ Botox Cosmetic _____Fillers

We recommend a full body examination. Please check whether you would like the full exam today or at a later date.

_____ Today _____ Defer

STUTZ DERMATOLOGY **JOSEPH A. STUTZ, M.D.**

Patient Information

Name of Patient _____

Social Security Number _____ M/F _____ Date of Birth _____

Address _____ Apt/Unit # _____

City _____State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____

Responsible party email address _____

Employer _____ Work Phone (___) _____ Ext. _____

Preferred method of appointment reminders (Circle all that applies) Home Phone Cell Email Text/SMS

Marital Status (check one) Single____ Married____ Divorced ____ Widowed____ Separated____

Is the patient a minor child? _____ If so, name responsible party _____

Emergency Contact: (please use a phone # not listed above)

Name _____ Relationship to Patient _____Phone (____)_____

******Do we have permission to share information with this person? Yes _____ No _____

Primary Insurance Information

Name of Insurance _____ ID# _____

Name of Cardholder _____ Social Security Number _____

Relationship to Patient (circle one) Spouse Parent Other _____ M/F ____ Date of Birth_____

Secondary Insurance Information

Name of Insurance _____ ID# _____

Name of Cardholder _____ Social Security Number _____

Relationship to Patient (circle one) Spouse Parent Other _____ M/F ____ Date of Birth_____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Who may we thank for referring you to our office? _____

I also certify that the above information is correct. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in the information above. If I have included a cell phone above I am giving the office or agent permission to call that phone. I request payment of authorized medical benefits to be made on my behalf to Dermatology Center of Rochester Hills, PC, Stutz Dermatology or Joseph A. Stutz, MD. I authorize any medical information needed to determine benefits payable to be released to my insurance company or its agent. **I understand that I am financially responsible for all charges whether or not paid by insurance**. Further, I authorize the use of this signature on all my insurance submissions whether manual or electronic.

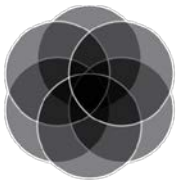
_____ _____ _____

Signature of Patient (Parent or Guardian) **Relationship to Patient** **Date**

Privacy Practices Acknowledgement (HIPPA Privacy Rule)
I have read the attached Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____ _____

Signature of Patient (Parent or Guardian) **Relationship to Patient** **Date**



STUTZ DERMATOLOGY

919 W. UNIVERSITY DR., SUITE 100, ROCHESTER MI 48307

PHONE: 248.651.9500 FAX: 248.651.3366

Authorization and Agreements of Medical Treatment
Insurance Benefits and Financial Responsibility

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Joseph Stutz, M.D., his associates, assistants or Dermatology Center of Rochester Hills, P.C. or Stutz Dermatology.
I understand the examination procedures will be explained to me and I shall consent to the partial or complete dermatological examination of the parts of my body I show to the examiner. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with my dermatologist. I hereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Joseph Stutz, M.D., his associates, assistants or Dermatology Center of Rochester Hills, P.C. or Stutz Dermatology. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

1. For patients with an office visit copay or without a participating insurance or for cosmetic services – payment is due at the time of service.
   We accept cash, checks, and credit card payments. There is a $25 fee for returned checks.
2. When seen for an appointment a payment is expected on any balance that is on your account.
3. Our office will submit claims to your insurance company as a service to you. It is important that you know if your insurance has a deductible, co-insurance and or copay. You should also know what your insurance plan covers. Deductibles, co-insurance, copays and services not covered by your insurance are your responsibility. Please speak to the office staff prior to your visit, if you have questions regarding your visit.
4. Your medical treatment may require several return visits to obtain results. Every time a medical treatment is provided there is a charge for your visit.
5. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware of any plan requirements.
6. If your insurance company is a managed care plan please review your coverage. If you require services that require a referral – adequate planning is essential. Referrals must be authorized by your doctor and usually require an office visit. Authorization from managed care plans for your referrals may take one or more days. Please be aware that we are often unable to accommodate call in requests for referrals. Do not expect our office staff to obtain your referral forms – this is your responsibility. Failure to obtain necessary authorizations often lead to out of pocket expense. We are happy to assist you in any way with your managed care plan however our experience with these plans has demonstrated that planning and adequate lead time are essential. Your knowledge of your plan regulations and benefits as well as adequate planning will help avoid delays and denied claims.
7. In the case of estranged or divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered – regardless of coverage arrangements. We will gladly furnish you with necessary statements for reimbursement.
8. Your doctor is here to manage your medical care. The physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial arrangements with the business office staff.
9. If you are experiencing financial difficulties please discuss this with the business office staff. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.

I have read the above Acknowledgements and Agreements and fully understand the same.

Patient's Name (Print):_____

Signature of Patient or Guardian: _____Date:_____

Relationship to Patient: _____Witness _____Date:_____