Name: _____DOB: _____

New Patient Packet

Family Medicine of Michigan

Thank you for your interest in becoming a new patient with David J. Smith, MD PC, dba Family Medicine of Michigan, the office of David J. Smith, M.D., Timothy J. Izzo, D.O., Eric G. Smith, M.D., Peter C. Miller, M.D., Edward D. Ball, D.O., Rowland W. Hinds, D.O., Jami deVarona, FNP-C, Shannon M. Biergans, FNP-C, and Tracy M. Wirth, FNP-C. It has been our pleasure to provide primary care medicine services in Grand Ledge and surrounding areas for more than 30 years.

The enclosed packet is designed to allow for a head-start at providing you with the excellent care that our office and providers are known for. It is imperative that you read through and understand the contents of this package and fill out the requested information completely before returning it to us. We cannot process your request to become a new patient until the attached forms have been completed.

How does the New Patient Application Process Work?
Complete and return the attached forms to Family Medicine of Michigan (FMOM). Forms can be returned by mail, fax, or dropped off in person at our reception desk. Family Medicine of Michigan, 1035 Charlevoix Drive, Suite 100, Grand Ledge, MI 48837 517-622-1242 (fax)

Please be advised that completing the attached forms does not establish a physician-patient relationship with Family Medicine of Michigan nor with any of our individual medical providers. FMOM will verify that your insurance is active and review your forms for completeness. Please note we can only accept a set number of new patients per month based on appointment availability and insurance ratios.

***Due to the high demand for our long-standing providers, it may be* several *months before an appointment can be scheduled*. Our newer providers have sooner availability. FMOM will contact you to set up your New Patient Exam. If for some reason, your medical needs require more immediate attention, we suggest that you either maintain your current medical provider or seek out another option for care.**

All patients are required to have a "New Patient Exam". This appointment will last about an hour and will be billed to your insurance as a Physical / Health Maintenance Exam. We recommend that you contact your insurance to verify this service will be covered. ***Medicare does not cover this service†.*** We do offer the Annual Wellness Exam as an option for Medicare patients as an alternative, which is a covered benefit. It is the patient's responsibility to know if they are eligible for this service. Our Tax ID #: 38-2253346.

A MISSED NEW PATIENT APPOINTMENT WILL NOT BE RESCHEDULED.

Age	Procedure Code	Diagnosis Code	Cost
8 days and under	99381	Z00.110	$205
8 – 28 days	99381	Z00.111	$315
28 days to 1 yr.	99381	Z00.129	$185
1 to 4 yrs	99382	Z00.129	$195
5 to 11 yrs	99383	Z00.129	$160
12 to 17 yrs	99384	Z00.129	$180
18 to 39 yrs	99385	Z00.000	$175
40 to 64 yrs	99386	Z00.000	$200
65 and over	99387	Z00.000	$220

† If it is determined that you do not have coverage for this service or do not have health insurance, pre-payment is required to schedule the appointment.

Name: _____DOB: _____

Please Print

Patient Information

You must fill out every line on this sheet

Name: _____Social Security #: _____
Last Name *First Name* *M.I.*

Mother's Name if minor patient: _____ Father's Name if minor patient: _____

Address:_____City:_____State:_____Zip:_____

Age: _____ Date of Birth: _____ Home #: _____ Cell #: _____

Email: _____ Work #: _____ **Circle your preferred contact number**

PLEASE CIRCLE

Gender: Male / Female **Marital Status:** Single / Married / Widowed / Separated / Divorced

Race: African American / Asian / Caucasian / Hispanic / Other: _____

Ethnicity: Latino/Hispanic or Other Do you require assistance for a hearing impairment? (Circle One) Yes / No

Preferred Language: _____ If not English, will you require an interpreter? (Circle One) Yes / No

Do you have a Living Will or Medical Advance Directive: Yes / No Will you provide FMOM a copy? Yes / No

Emergency Contact

Name: _____ Home #: _____

Address: _____ Cell #: _____

City/State/Zip: _____ Work #: _____

Relationship: _____

Do you have a request as to which provider you would like to see:

Have you ever been a patient at Family Medicine of Michigan?

Please list any family members who are currently patients at FMOM and their relationship to you:

Who was your primary care provider and what is the reason(s) you are leaving that provider?

Are you under the care of any other health care provider for any medical problems? Yes / No

If yes, list whom and for what medical condition.

_____

_____

_____

Name: _____DOB: _____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD – FRONT AND BACK

Primary Insurance Information

Policy Holder Information

Name: _____
Last *First* *Middle*

Date of Birth: _____ Relationship to Patient: _____

Insurance Carrier: _____
Name *Address* *Phone Number*

Member ID._____ Group No. _____ Copay: _____ Deductible: _____ Co-Ins:. _____

Policy Holder Employment Information

Policy Holder Employer: _____ Occupation: _____

Business Address_____ City: _____ State: _____ Zip: _____

Business Phone Number: _____

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Secondary Insurance Information

Policy Holder Information

Name: _____
Last *First* *Middle*

Date of Birth: _____ Relationship to Patient: _____

Insurance Carrier: _____
Name *Address* *Phone Number*

Member ID._____ Group No. _____ Copay: _____ Deductible: _____ Co-Ins:. _____

Policy Holder Employment Information

Policy Holder Employer: _____ Occupation: _____

Business Address_____ City: _____ State: _____ Zip: _____

Business Phone Number: _____

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Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance carriers. I hereby give my permission and grant authorization to David J. Smith, MD PC dba Family Medicine of Michigan to use any and all information gathered to verify benefits under these insurers for myself and my dependents.

Primary Policy Holder Signature _____Relationship _____Date _____

Secondary Policy Holder Signature _____Relationship _____Date _____

Name: _____DOB: _____

Current Medical History

Please indicate each of your chronic medical problems by marking the appropriate box below: ☐ None

☐	High Blood Pressure	☐	Asthma
☐	Heart Disease (Describe Type Below)	☐	Emphysema
☐	Diabetes	☐	Kidney Problems
☐	Stroke	☐	Anemia
☐	Cancer Type: _____	☐	High Cholesterol
☐	Thyroid	☐	Depression/Anxiety

List any other medical conditions / problems:

List all medications that you are now taking, strength and how often. Indicate in left column with an "X" if you wish to have our providers manage the medication. No Medication ☐

X	Medication	Strength (mg.)	Directions (ex. Once per day)

Are you allergic to any medications? If so, please list medication and reaction:

Please list any other allergies and their reaction:

Name: _____DOB: _____

Please list any childhood diseases (ex: chicken pox): ☐ None

Social History

Tobacco _____ a day

# of years _____ Year Quit _____

Exercise _____

Times per week (min/session) _____

Street Drugs _____

Alcohol _____drinks per week

Caffeine _____ cups per day

Water _____ cups per day

Low fat diet (circle one) Yes / No

Women Only

Age at first menstrual cycle: _____

Date of first day of last menstrual period: _____

Number of pregnancies: _____

Number of live births: _____

Date of last PAP? _____

Date of last Mammogram: _____

Men Only

Date of last Prostate Exam: _____

Date of last PSA: _____

Procedures

Indicate years and results if known

☐ None

Procedure	Year(s)	Results
DEXA		
Stress Test (Heart)		
Doppler		
Ultrasounds		
Angiography		
EKGs (ECGs)		
MRI		
MRA		
CT Scan		
Colonoscopy		
Sigmoidoscopy		
Mammogram		
PAP		

Name: _____DOB: _____

Please list any surgeries/hospitalizations (including the year): ☐ None

Immediate Family History

If any blood relative has suffered the following conditions, check the box and **indicate which relative.**

☐	Heart Disease	☐	Asthma
☐	Diabetes	☐	Emphysema
☐	Thyroid	☐	Cancer Type _____
☐	Stroke	☐	Glaucoma
☐	High Blood Pressure	☐	Mental Health
☐	High Cholesterol	☐	Substance Abuse

Immunization History

Please list your immunization history (You may also include a copy of the immunization):

Childhood Immunization:	**Date:**
DTaP (diptheria and pertusis) 1	
DTaP (diptheria and pertusis) 2	
DTaP (diptheria and pertusis) 3	
DTaP (diptheria and pertusis) 4	
DTaP (diptheria and pertusis) 5	
Polio 1	
Polio 2	
Polio 3	
Polio 4	
Hepatits B 1	
Hepatits B 2	
Hepatits B 3	
Hib (Haemophilus influenza b) 1	
Hib (Haemophilus influenza b) 2	
Hib (Haemophilus influenza b) 3	
Hib (Haemophilus influenza b) 4	
PCV 13 (Pneumococcal) 1	
PCV 13 (Pneumococcal) 2	
PCV 13 (Pneumococcal) 3	
PCV 13 (Pneumococcal) 4	
MMR (measles, mumps, rubella) 1	
MMR (measles, mumps, rubella) 2	
Rotavirus 1	
Rotavirus 2	
Rotavirus 3 (only needed if RV5)	

Adolescent / Adult:	**Date:**
Meningococcal 1	
Meningococcal 2	
HPV (Human papillomavirus) 1	
HPV (Human papillomavirus) 2	
HPV (Human papillomavirus) 3	
Influenza (last date given)	
Tetanus (last date given)	
Varicella (chickenpox) 1	
Varicella (chickenpox) 2	
Hepatitis A 1	
Hepatitis A 2	
Zostavax (shingles)	

Other injections not listed:	

Name: _____DOB: _____

Notice of Office Policies and Procedures for New Patients:

Family Medicine of Michigan is a BCBSM designated Patient-Centered Medical Home. This means that we have established policies and procedures to create and maintain a partnership with patients for the care we provide. We make every effort to ensure that the health care we provide includes preventive care as well as acute and chronic disease management and we put you at the center of that care.

This is not an exhaustive list of all of the office policies and procedures. Visit ***www.familymedicineofmichigan.com*** for the full text of our policies referenced here. Feel free to contact our office to clarify any of the information prior to submitting your new patient forms.

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with FMOM.

- Newly accepted applicants are not considered patients until they have been seen by a provider for the new patient physical appointment.
- Any patient that has had a three year absence and has not had an appointment by a provider in our office will not be considered a patient. Former patients that would like to be reestablished as patients will need to go through our New Patient process and be reaccepted.
- While Family Medicine of Michigan verifies your insurance, patients are responsible for understanding the terms of their medical insurance contracts and if a service that we provide is a covered contract benefit. Patients are responsible for payment if a service is rendered and the medical insurance denies payment.
- We keep same day appointments available for our patient's acute care needs. However, you may need to see a provider other than your regular provider for these appointments depending on schedules.
- Family Medicine of Michigan does not allow patients to incur balances on an account. All patients must have an account guarantor and a secure method of payment on file that guarantees payment for services rendered. Any time a payment method does not satisfy a charge and a statement has to be generated there will be a $5 statement fee assessed. The Practice Financial Policy and Practice Family Account Policy are available online.
- Co-pays and any outstanding balance MUST be paid at the time services are rendered. Family Medicine of Michigan reserves the right to reschedule your appointment if you do not have payment or do not have a method of secure payment on file for co-pays, co-ins, deductible amounts, or balances on the day of your appointment. We may not process medical or administrative requests for services if there is an outstanding balance on your family account. The Practice Family Account Policy is available online.
- We will accept refill requests via telephone, fax, or online but it may take up to 72 hours for processing. It may also be required for you to have an office visit with your provider in order to process a refill request.
- All refill requests for controlled substances must be made with your primary prescribing physician at the time of your regularly scheduled appointment. No other requests for refills of controlled substance medications will be processed. The Practice Controlled Medication Policy is available online.
- **WE CANNOT SEE YOU IF YOU HAVE MEDICAID INSURANCE.** Medicaid requires that you see one of their participating providers for services. We do not participate with Medicaid and cannot accept any patients that have Medicaid insurance either as primary or as secondary insurance.
- **FAMILY MEDICINE WILL NOT MANAGE CHRONIC PAIN MEDICATIONS**.
- Chiropractic care services are not generally a treatment option we employ. Even if your insurance covers Chiropractic services we will generally not elect to refer you for treatment by a Chiropractor.
- We seldom refill medications for more than six (6) months at a time, therefore regular checkup appointments will be necessary for all maintenance medications. We do not call in prescriptions for new medications over the phone and will not make any changes to medications without an appointment.
- **FAMILY MEDICINE OF MICHIGAN HAS A NO SHOW POLICY.** Any time you fail to give us a 24-hour notice of a cancellation, the missed appointment will be considered a No-Show Appointment. More than three (3) No-Show appointments in a one-year period may result in termination of our relationship. Reminder notifications of your appointments are considered a courtesy. It is ultimately the patient's responsibility to maintain all appointments. FMOM does not have a cancellation line when the phone lines are closed. The Practice No-Show Policy is available online. **A MISSED NEW PATIENT APPOINTMENT WILL NOT BE RESCHEDULED.**
  No-Show fees are as follows:
  $25.00 for a missed general appointment **$100.00** for a missed Physical / Health Maintenance Exam (HME)

Please sign below stating that you have read, understand and agree to abide by all Family Medicine of Michigan policies and procedures.

Signature of Patient or Legal Guardian_____ Date _____

Print Name of Patient or Legal Guardian _____Relationship _____