Name:_____ DOB:_____

New Patient Packet

Family Medicine of Michigan

Thank you for your interest in becoming a new patient of Robyn D. Messing, D.O., a Board-Certified Family Physician emphasizing Dermatology with Family Medicine of Michigan. We look forward to serving your dermatologic needs.

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 ask that you complete this packet and return it to us so that we can schedule your new patient appointment. You may mail or fax the forms to our office using the following information:

Family Medicine of Michigan – Dr. Messing
2815 S. Pennsylvania Ave, Suite 107
Lansing, MI 48910

Phone: 517-372-2253 Fax: 517-372-2287

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.

MEDICAID PATIENTS: A missed new patient appointment will not be rescheduled without a new referral from your primary care physician.

COMMERCIAL PATIENTS: A fee will be assessed for a missed new patient appointment. The new patient appointment will not be rescheduled until that fee has been paid.

Name:_____ DOB:_____

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: _____

Legal Guardian's Name if applicable: _____

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

Emergency Contact

Name: _____ Home #: _____

Address: _____ Cell #: _____

City/State/Zip: _____ Work #: _____

Relationship: _____

What provider has referred you to Dr. Messing?

What provider is your primary care provider?

Do you have a Durable Power of Attorney?

If yes, we must have a copy of this legal document at the time of check-in for your first appointment. The DPOA must be in attendance or have signed a consent form to allow treatment in their absence.

If the patient is a minor, who is financially responsible for the account? If contact information is different than listed above, please provide contact information (address and/or phone number).

What is the reason for initial visit?

_____

_____

_____

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

☐	Eyes	☐	Arthritis/Muscles/Joints/Bones	☐	Hepatitis C
☐	Ears/Nose/Throat	☐	Headaches/Seizures/Neurological	☐	HIV
☐	Heart/Vessels	☐	Psychological disorder	☐	
☐	High Blood Pressure	☐	Thyroid/Diabetes/Endocrine	☐	
☐	Lungs	☐	Blood/Bleeding Disorder	☐	
☐	Kidneys	☐	Allergic/Immunologic	☐	

Females: Are you pregnant? ☐ Yes ☐ No Are you planning on becoming pregnant? ☐ Yes ☐ No

Are you taking hormones or birth control pills? ☐ Yes ☐ No

Please explain/specifiy any items marked above.

List all medications that you are now taking, strength and how often.

☐ Mark box if taking no medications.

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

Please list any allergies:

Name:_____ DOB:_____

Social History

Tobacco _____ a day

Alcohol _____drinks per week

# of years _____ Year Quit _____

Recreational Drugs_____

Do you live alone? ☐ Yes ☐ No

Hobbies/leisure activities: _____

Immediate Family History

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

	Mother	Father	Blood Relative	
Allergies				
Arthritis				
Asthma				
Cancer Type_____				
Diabetes				
Eczema				
Hay Fever				
Heart Disease				
High Blood Pressure				
Lung Disease				
Malignant Melanoma				
Psoriasis				
Skin Cancer				
Tuberculosis				

Information Release

The information below will assist us in your care and in any communications with you, while protecting your confidentiality. Please review, circle choices, and fill in any necessary information. You may amend this statement at any time by submitting a written request.

YES NO Use your email, home phone, and cell phone to provide you with email reminders.

***If you say no to this you will not receive any type of reminder from our office.

YES NO Leave a message on your home or cell phone requesting a return call.

YES NO Leave a message on your home or cell phone with test results.

YES NO Contact you at your work regarding your healthcare. (Work#_____)

YES NO Leave a message on your work voice mail regarding your health care.

Name:_____ DOB:_____

Notice of Office Policies and Procedures

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. The policies listed below pertain primarily to the dermatologic care provided by Robyn D. Messing, D.O.

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 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 compete any applicable paperwork.
- 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.
- 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.
- Rpbyn D. Messing, D.O. is the only provider in the Family Medicine of Michigan group that accepts **Medicaid insurance**.
- **FAMILY MEDICINE WILL NOT MANAGE CHRONIC PAIN MEDICATIONS**.
- **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 ONLY BE RESCHEDULED AS PER THE TERMS OUTLINED ON PAGE ONE.**

  No-Show fees are as follows:

  $25.00 for a missed general appointment **$50.00** for a missed Full Body Mole Check

IT IS YOUR RESPONSIBILTIY TO KNOW YOUR INDIVIDUAL INSURANCE POLICY. MANY INSURANCE POLICIES HAVE EXCLUSIONS, AND MOST HAVE DEDUCTIBLES AND CO-PAYMENTS. SOME INSURANCE POLICIES MAY NOT COVER OUR SERVICES.

IT IS IMPORTANT FOR YOU TO CHECK WITH YOUR INSURANCE CARRIER TO DETERMINE IF THE PROVIDER YOU ARE SEEING IS LISTED AS AN **"IN NETWORK"** PROVIDER. IF THEY ARE NOT LISTED AS AN **"IN NETWORK"** PROVIDER, YOU MAY HAVE A HIGHER DEDUCTIBELE OR CO-PAYMENT.

REGARDLESS OF INSURANCE COVERAGE, YOU ARE RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY YOUR INSURANCE POLICY.

_____

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 _____