Dearborn Family Clinic Patient Registration Form

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be kept confidential. PLEASE PRINT

Date: _____ *Reason For Visit: _____

Patients Name: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Marital Status: S M W D Sex: F M Age: _____ Race: _____
Cell Phone: _____ Home Phone: _____
Email: _____
Spouse / Emergency Contact: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Birthdate: _____ Relationship: _____
Insurance: _____ Responsible Party: _____
Phone: _____ Birthdate: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Pharmacy: _____ City: _____ Phone: _____

Authorization and Assignment

Dear Patient:

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. **It is your responsibility to know your individual coverage – Deductibles, Co-pays, Co-Insurances. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.** Please remember your insurance coverage is between you and your company and not between your company and doctor.

Signature: _____ **Date:** _____ **Witness:** _____

I request the payment of authorized Medicare/Other insurance company benefits be made on my behalf to Dearborn Family Clinic, P.C. for any services furnished to me by the Physician/Supplier. I authorize the holder of medical information about me to release HCFA and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer(s) or agency(s) shown in my file. In Medicare/Other Insurance company assigned cases, the Physician or Supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible for any deductible, coinsurance and non-covered services.

Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.

I understand that I am personally responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance with our office.

Signature: _____ **Date:** _____ **Witness:** _____

In the event of a change in insurance company or coverage, the above Authorization and Assignment stand true.

Signature: _____ **Date:** _____ **Witness:** _____

DEARBORN FAMILY CLINIC, P.C.

Dearborn Family Clinic
3133 S. Telegraph
Dearborn, MI 48124
Phone: (313) 565-6566
Fax: (313) 827-0018

The Patient – Doctor Partnership Agreement

The health and wellness of our patients is a top concern of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, your doctor, and you, my patient work together. This concept is called the Patient – Doctor Partnership.

Patient Responsibilities:

- Ask questions, share your feelings, and be part of your care
- Be honest about your history, symptoms and other important information
- Discuss any changes in your health and wellbeing
- Take all of your medicine and follow your Dr's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for, keep or reschedule appointments in advance
- Call your Dr first with all problems, unless a medical emergency
- End every visit with a clear understanding of your Dr's expectations, treatment goals & future plans.

Doctor Responsibilities :

- Explain findings, treatments, and results in an easy –to-understand way
- Listen to my patient's feelings & questions to help them make informed decisions about their care
- Keep treatments, discussions, and records private
- Provide 24hr access to medical care and same day appts whenever possible
- Provide instructions on how to meet health care needs when the office is not open
- To care to the best of my abilities based on my understanding of current medical methods available
- Give my patients clear directions about their medicines and other treatments
- Send my patients to trusted experts if needed
- End every visit with clear instructions about treatment goals, expectations, and future plans

Patient #: _____ **Date of Birth:** _____

Patient Name: _____

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

DEARBORN
FAMILYCLINIC, P.C.
DAY AND WEEKEND CARE

)133 S. Telegraph
)earborn, MI 48124

313) 565-6566
313) 561-5554 Fax

Patient Name: _____ Date: _____

We At, Dearborn Family Clinic, P.C., are required by the federal and state laws to educate all patients 18 years and older on *Advanced Medical Directives and self-determination policies*.

An Advanced Directive document indicates and stipulates a person's choice of treatment should they become mentally unable to make decisions for themselves due to injury or illness. A living will, durable power of attorney, or code status in case of emergency, is some of the choices that illustrate an Advanced Directive. It allows a person to state how medical decisions are to be made when his/her ability is lost.

1. Do you have an Advanced Directive?

   _____Yes _____No

2. Do you want information on Living Wills and Advanced Directives?

   _____Yes _____No

3. Education materials on Advanced Directives given to patient?

   _____Yes _____No Date: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

ADULT MEDICAL HISTORY

DATE: / /

PATIENT NAME	BIRTHDATE	AGE	SEX
	/ /		M F

PERSONAL ILLNESS OR MEDICAL PROBLEMS

Please mark with an "X" any of the following illnesses and medical problems you have, or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year.

ILLNESS	"X"	YEAR	ILLNESS	"X"	YEAR	ILLNESS	"X"	YEAR
Eye or Eye Lid Infection			Arteriosclerosis			Epilepsy		
Glaucoma			Heart Murmur			Head Injury		
Cataract			Other Heart Condition			Stroke		
Other Eye Problems			Stomach / Duodenal Ulcer			Convulsions, Seizures		
Deafness			Diverticulosis			Arthritis		
Ringing Sound in Ears			Colitis			Cancer or Tumor		
Bronchitis			Gout			Bleeding Tendency		
Emphysema			Yellow Jaundice			Diabetes		
Pneumonia			Liver Trouble			Hepatitis		
Allergies			Gall Bladder Trouble			Measles		
Asthma			Hernia			Mononucleosis		
Tuberculosis			Hemorrhoids			Psoriasis		
Other Lung Problems			Kidneys or Bladder Disease			Other Skin Problems		
High Blood Pressure			Prostate Problem(s)			Mental Illness		
Heart Attack			Migraine Headaches			Alchoholism		
High Cholesterol								

FAMILY HEALTH HISTORY

Relationship	Age if Living	Age at Death	State of Health or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

Please indicate any BLOOD relatives that have had any of the following:

Illness	Family Member	Illness	Family Member
Diabetes		Alcoholism	
Cancer: type?		Mental Illness: type?	
Blood Disease		Gout	
Glaucoma		Gallstones	
Seizures / Epilepsy			
Arthritis			
Tuberculosis			
High Blood Pressure			
Heart Disease			
Kidney Disease			

HOSPITALIZATIONS AND SURGERIES

Check box if NONE ☐

Please list the last four times, if any, that you have been hospitalized. Do not include normal pregnancies.

YEAR	Operation or Illness	Hospital & City

CURRENT MEDICATIONS

Check box if NONE ☐

Please list all Medications you are now taking. Include those you buy without a Doctor's prescription (such as aspirin or cold tablets).

Medication Name	Dosage	Frequency

ALLERGIES to Medications

Check box if NONE ☐

Please list any allergies to Medications you have had.
Please DO NOT INCLUDE food allergies or hay fever.

SOCIAL HISTORY

Your Occupation:

Your Marital Status:
Single Married Divorced Widowed Separated

Have you ever been exposed to chemicals or other harmful substances at work or elsewhere? YES NO If yes, explain:

You currently live:
Alone with Friends with Parents with Family

Last Grade completed in school:
6 7 8 9 10 11 12 College: 1 2 3 4 Graduate School

Do you feel your life is stressful? YES NO

Did you have radiation treatment as a child? YES NO

Date of Last Tetanus Vaccination:

Please describe your eating habits:

Please describe your exercise habits, type and frequency:

Are there any medical or psychological problems that run in your family? YES NO If YES, please explain.

SMOKING: Do you currently Smoke? YES NO Are you a former Smoker / Tobacco user? YES NO When did you quit?

If Yes to either question, circle the tobacco you use(d): Cigarettes Cigar Pipe Chewing Tabacco

How much per day? How many years?

DRINKING: Do you currently Drink? YES NO

If Yes, what kind(s) of alcohol do you drink?

How much do you drink on one occasion?

How often do you drink? daily a few times a week once a week once a month other?

DRUG USE: Do you (or have you in the past) used : Marijuana YES NO

Cocaine YES NO

Previous I. V. Drugs YES NO

Other Drugs, Specify: YES NO

Do you drink coffee, tea or colas? YES NO If YES, how much per day?

FEMALE ONLY

Age Menstrual Period Began:

Date Last Period Began:

Could you possibly be pregnant at this time? YES NO

Age at Menopause:

Pregnancies:
LIVE BIRTHS # MISCARRIAGES
CESAREAN # PREMATURE
STILLBORN # ABORTIONS

How many living children:

Method(s) of Contraception used:

Date of Last Mammogram:

Date of Last Pap Smear: POSITIVE / NEGATIVE

- ☐ Vaginal Itching or Burning
- ☐ Vaginal Discharge
- ☐ Problem with Menstrual Periods
- ☐ Sexual Difficulties
- ☐ Lumps in Breast(s)
- ☐ Veneral Disease
- ☐ Discharge from Nipple(s)
- ☐ Tubal Ligation
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Other problem(s), please describe:

MALE ONLY

- ☐ Hernia
- ☐ Discharge from Penis
- ☐ Pain in Testicles
- ☐ Veneral Disease
- ☐ Sexual Difficulties
- ☐ Vasectomy
- ☐ Other problem(s), please describe:

Please add any other comments not covered above:

Pharmacy: _____

Address: _____

_____

Phone: _____

NOTICE

Due to the constant changes in insurance, it is no longer possible to interpret each individual's policy. Although we try to stay aware of the changes,
It is not possible.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE

Please do not get angry at us if your insurance does not cover our services. All insurance policies have exclusions and most policies have deductible and co-pays which can change yearly.

Please remember that your insurance policy is between you and your insurance company and **NOT** between the insurance company and the doctor.

_____ _____

Patient name (printed) Date of birth

_____ _____

Signature of insured or responsible party Date

DEARBORN FAMILY CLINIC, P.C.

PATIENT CONFIDENTIALITY FORM

Due to the new HIPPA regulations we are unable to discuss your medical condition with your family members unless we have written consent from you.

I_____(patient name) authorize Howard M. Wright D.O. and the representatives of his office to discuss any medical condition and treatment with my family member who are as follows:

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information.

Signature below gives us your permission to share your medical information with the above named designated family members.

_____ _____

Signature Date

_____

Witness

Dearborn Family Clinic
3133 S. Telegraph Rd.
Dearborn, MI 48124
Phone: 313-565-6566
Fax: 313-827-0018

PAYMENT POLICY FOR SERVICES RENDERED / 24 HR CANCELLATION & NO SHOW FEE POLICY

Co-pays & Deductible Policy:

You are responsible for payment of your designated co-pay & deductible at each visit **BEFORE** you see the doctor. This arrangement is part of your contract with your insurance company. If your copay is not paid at time of service, our office will bill you a $5 processing fee for your copay which will then be due at the window upon your return office visit along with that office visits fees (Past Copay, processing fee, & Copay).

We accept cash, check, Visa, Mastercard and Discover. All returned checks will be assessed a $35.00 returned check fee in addition to the original charge.

24 Hour Cancellation & "No Show" Fee Policy:

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, DFC reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

I acknowledge and understand these office policies and procedures.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Dearborn Family Clinic
3133 S. Telegraph Rd.
Dearborn, MI 48124
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Dearborn Family Clinic Receipt Acknowledgement of Notice of Privacy Practices

The Dearborn Family Clinic Notice of Privacy Practices describes in more detail how your health information can be used or disclosed and how you can access your information. We maintain a record of the healthcare services that we provide you and you may ask to see and copy your medical record. You may also ask to correct the record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

By your signature below, you affirm that you have received and read a copy of Dearborn Family Clinic's notification policies and procedures. You further understand that you can ask any questions that you may have about these policies and procedures.

Name of Patient:_____

Patient Signature:_____Date: _____

Signature of Patient Representative*:_____

Relationship to Patient:_____ Date:_____
**Required if the patient is a minor or an adult unable to sign this form*

For office use only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:
__Patient refused to sign
__Communications barriers prohibited obtaining the acknowledgement
__An emergency situation prevented us from obtaining acknowledgement
__Other _____

Employee Signature: _____Date:_____

Let's Make The Most Of Your Visit!

You can make the most of your time with your doctor by being prepared. Let your doctor know your symptoms and concerns up front in case more than one appointment is needed. By doing so, the most important issues are addressed immediately.

Here are some actions to take to make the most of your appointment:

- Request any refills, supplements, or samples with your Medical Assistant (MA) before leaving the room
- Verify/Update your current Pharmacy with the Medical Assistant
- Discuss any changes in your health since you last visited.
- Discuss your list of questions and concerns with the doctor.
- Bring a list of all medications you are currently taking, including how many times per day, the dose strength, and the name of the pharmacy you use.
- Understand when and how to take the medications.
- Know how and when you will receive your test results.
- Be sure you have received any scripts needed for your prescriptions and that they are correct

Be sure you understand and follow the directions given to you by your doctor. This is an important part of your responsibility as a patient. So before you leave the room, ask any questions you may have about your medications, tests, referrals, scripts, and when to call the doctor.

Follow through with your care at check-out by:

- Scheduling your follow-up appointment if required, and/or any future appointments.
- Picking up any supplements or samples you requested from your MA
- Picking up your scripts for any procedures such as an MRI, Physical Therapy, & UltraSounds and making sure that they are correct before leaving.

Please do not leave without stopping at checkout. Thank you

Dearborn Family Clinic is committed to providing quality care to our patients. Due to a high volume of calls, we are encouraging patients to use our automated phone system and use the following telephone prompts when calling the office:

Prompt 1: Prescription refills, Supplements, or Samples – Leave a clear & detailed message with your name, phone number, date of birth, which pharmacy you use, and name of prescription, supplement, or sample you are requesting. Please allow 1 to 3 business days for requests to be filled. Receptionist cannot take requests and requests cannot be processed without leaving a message.

Prompt 2: Scheduling, Forms, Letters –We are happy to help you schedule,reschedule,or cancel a non same-day appointment. We also understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at DFC will be happy to complete these forms and writemedical letters as necessary upon request. However, this can be time consuming, so please allow 3-5 days for completion of requested forms/letters.

Medical Records – Per HIPAA guidelines, copies of medical records must be requested in writing and completed prior to receipt of records. All patients can request 1 copy of medical records free of charge. Additional copies can be requested for a fee. Please allow 3-5 days for completion of request

Prompt 3: Test Results - Leave a clear & detailed message with your name, phone number, date of birth. Medical Assistants check this line several times throughout the day and will return your call in the order in which it was received.

Prompt 4: Billing Department - In addition to providing you with the best available care, DFC is committed to convenient and reliable billing services. If you would like to discuss our billing in person, please call ahead to make an appointment.

Prompt 5: Office Manager

Prompt 6: Office Hours & Directions

Prompt 9: Clinical Directory
Option 1 – Dr, Wright
Option 2 – Lisa Boros-Laurain
Option 3 – Michael Baldwin
Option 4 – Angela Harris
Option 5 – Rachel Eshkanian

Thank you for understanding while we transition into our new policy. We appreciate your cooperation.

DFC Staff

Dearborn Family Clinic, P.C.

YOUR PARTNER IN EXCELLENT HEALTH CARE

Welcome to the Dearborn Family Clinic, your partner in excellent health care and Patient Centered Medical Home (PCMH). When you choose Dr. Wright as your primary care physician, your health becomes our responsibility and we work as hard for your health as you do. We all share that commitment, setting high standards for ourselves and the quality of our care and we deliver on that promise through caring, convenience, and qualifications.

We will attempt to have you see Dr. Wright at each of your appointments. However, if he is not available, our Physicians Assistants work as a team and use our electronic medical records to provide coordinated care.

Combing services and programs is a growing trend for our practice to help our patients find multiple services at a single site. Dearborn Family Clinic proudly offers X-rays, Ultrasounds, as well as in-house laboratory for patient convenience.

Scheduling Appointments

When you call the office, be sure to tell the receptionist the reason for your visit so we can plan on a date and time that is most convenient for you. Appointments for Physical Exams Routine Visits are always available and can be scheduled as needed. We know that illnesses are unexpected and we will gladly work around your schedule to bring you in for immediate care and attention.

Regular Office Hours
Telephone: 313-565-6566

Monday	**8:45am – 6pm**
Tuesday	**8:45am – 4:15pm**
Wednesday	**8:45am – 5:00pm**
Thursday	**8:45am – 4:30pm**
Friday	**8:00am – 1:30pm**
Saturday	**8:00am – 12pm**

Urgent Care Center
Telephone: 313-593-7000

Beaumont Urgent Care – Southgate
15777 Northline Rd
Southgate, Michigan
48195
734-324-9580
See Full List of Urgent Care Centers

Extended Hours and After Hours

Health care emergencies can happen anytime. If you have an urgent problem and the office is closed, we can be reached after hours by calling **734-504-9425**. We are on call 24 hours a day. If you do happen to go to the Emergency or Urgent Care, it is your responsibility to inform the practice regarding care with any other health care facilities and providers.

First Visit and Follow Up Visits

On your visit, check in at the receptionist desk so your information can be reviewed for accuracy. You ca help us serve you better by notifying the receptionist of any changes in name, address, telephone numbers, or insurance coverage. Verifying this information at each visit will help ensure the accuracy of submitting your services to our insurance company in a timely manner.

We try to follow our scheduled appointments as closely as possible. However, due to unavoidable circumstances or emergencies, a doctor may have to spend additional time with a patient who may have had an appointment prior to yours. This may result in a delay in seeing your doctor. We appreciate your patience and understanding in such circumstances.

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URGENT CARE FACILITY PREFERRED LIST

We are pleased to offer our patients preferred Urgent Care facilities that will inform us of your visit, as your Patient-Centered Medical Home we have partnered with the following Beaumont Urgent Care facilities. In the case of a medical emergency please contact Dr. Wright or the Provider on call before going to the Emergency Room. If instructed to go to Urgent Care please choose one of the following partnered facilities nearest you.

Dr. Wright may be reached any time ***after hours*** by calling his cell phone at **(248) 752-2501**. The Provider on call may be paged ***after hours*** at **(734) 504-9425.**

Beaumont Urgent Care- Southgate
15777 Northline Rd.
Southgate, Mi. 48195
(734) 324-9580 (8.3 miles from our office)

Beaumont Urgent Care – Redford
15540 Beech-Daly
Redford Twp. Mi. 48239
(313) 592-6330 (9.2 miles from our office)

Beaumont Urgent Care- West Bloomfield
6900 Orchard Lake Rd Suite 100
West Bloomfield, Mi. 48322
(248) 855-4134 (19.5 miles from our office)

Beaumont Urgent Care- Royal Oak
3535 W. 13 Mile Rd. LL
Royal Oak, Mi. 48197
(248) 551-1210 (20.7 miles from our office)

Beaumont Children's Pediatric After Hours Clinic- Beaumont Hospital Troy
44201 Dequindre Rd
Troy, Mi. 48085
(248) 964-2888 (35.5 miles from our office)