Northville-Novi Family Medicine
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21580 Novi Road, Suite 200
Novi, MI 48375
Office (248) 946-4905
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NEW PATIENT INFORMATION FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Age: _____ Sex: _____ SSN: _____

Current Address: _____City:_____ Zip Code: _____

Telephone (home): _____ (cell): _____ (work): _____

What number can we leave a message? _____

Occupation: _____ Employer: _____

Email: _____

May we contact you via email regarding appointments? _____

May we leave a voicemail message at the above phone number(s) regarding appointments &/or test results? _____

Emergency Contact (name & phone): _____

Social History

Who lives in your home with you? _____

Are you married? _____ Spouse name: _____

Do you have a significant other? _____ Name: _____

Do you currently use tobacco? _____ Have you EVER used tobacco? _____

What type, (cigarettes, cigars, chewing), how much daily and for how long? _____

Do you drink alcohol?_____ How many drinks per day? _____ Week? _____ Month? _____

What do you do for exercise? _____ How often? _____

Please circle: Right handed or Left handed

Insurance Info

Name of Primary Insurance: _____

Name of Insured: _____Date of birth: _____ Relationship:_____

Member ID: _____ Group:_____

Do you have any secondary medical insurance? _____

Medical History

Please list your medical problems such as diabetes, high blood pressure, depression, anxiety, arthritis, etc.:

_____

_____

_____

List all of your current medications and dosages:

_____

_____

_____

List any medication & food allergies, and what kind of reaction.

_____

_____

List your surgeries, year and any complications:

_____

_____

_____

List your natural children, their ages and any medical problems:

_____

_____

List your natural parents' year of birth, any medical problems, and age and reason of death if applicable:

_____

_____

List your siblings' ages and medical issues:

_____

_____

_____

List any pertinent medical history with your aunts, uncles or grandparents:

_____

_____

When was your last tetanus?_____

When was your last flu shot?_____

Have you had the meningitis vaccine?_____When?_____

Have you had the pneumonia vaccine? _____When?_____

Have you had the shingles vaccine?_____When?_____

List your prior physician name, address, & phone:

May we contact this physician to obtain medical records? _____

Are you allergic to latex? Yes or no

Have you ever received psychological treatment? Yes or no

If so, what type, for how long and when?_____

_____

Have you ever received treatment for alcohol or drug abuse? Yes or no

If so, what kind and when? _____

Do you have a living will? Yes or No

Do you feel safe at home?_____

How did you hear about us? Please circle one of the below options:

Phonebook	Newspaper	Internet
Word of Mouth	Insurance Company	Drove By

Other (please describe) _____

Signature_____ Date: _____

NORTHVILLE-NOVI FAMILY MEDICINE
Dr. Victoria N. Dooley, MD
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Please Read In Its Entirety & Sign Below

I understand that all medical costs incurred by me are my responsibility, including any charges my insurance fails to pay and/or any deductibles or co-insurance that my insurance coverage requires. I also understand that I am responsible to pay for any co-payments at the time of service.

Any outstanding balances will be billed and subject to interest if not paid in full within 21 days. Any unpaid accounts that must be sent to collections will be assessed a $30 late fee, and the maximum amount of interest allowed by law.

In order to provide the best possible service and availability to all of our patients, it is policy to charge a $20 fee for any appointments not cancelled within at least 24 hours notice.

I authorize Northville-Novi Family Medicine to submit all necessary documentation needed to receive payment from my insurance company. All payments billed to my insurance for my medical care will be made payable to Northville-Novi Family Medicine and not myself.

I have read & understand the above policies; and I agree to them.

Patient or Guardian's Signature: _____ Date: _____

Printed Name: _____