Welcome To Our Practice

JULIE L. HENRY, MD, PC
27427 SCHOENHERR ROAD, SUITE 200
WARREN, MI 48088

www.juliehenrymd.com
Telephone (586) 754-4417
FAX (586) 754-4473

Patient Name: _____ _____ _____ **Age:** _____ **Date:** _____
First **Middle** **Last**

Address: _____ **Email:** _____

City: _____ **State:** _____ **Zip:** _____ **Birthdate:** _____

Cell Phone: _____ **Home Phone:** _____ **Soc. Sec #:** _____-_____-_____

Emergency Contact: _____ **Phone:** _____

Marital Status: **Single / Married / Divorced / Widowed** **Sex:** **Male / Female**

Family Physician: _____ **PCP Phone:** _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Employer: _____ **Work Phone:** _____

Work Address: _____ **Occupation:** _____

Referred From: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ **ID#:** _____

Susbscriber Name:_____ **Subscriber DOB:** _____

Secondary Insurance Name: _____ **ID#:** _____

Susbscriber Name:_____ **Subscriber DOB:** _____

Parent / Guardian / Responsible party: _____ **Phone:** _____

You must present valid ID and insurance cards at the time of your visit.

***** If your insurance requires a referral, you must have this prior to your appointment*****

Please pay copays at the time of your office visit. Unpaid balances may be turned over to a collection agency or attorney. Accounts in collections are subject to 35% collection fees as well as monthly interest rates of 1.5% added to the total balances.

Protected Health Information (PHI) will be disclosed to confirm appointments, to counsel caregivers on my treatment, for prescription prescribing and any other reason for treatment and care delivered by Julie L. Henry, MD, PC. I understand that I can revoke this authorization in writing at any time. Any changes to your PHI should be directed to our office in writing. I understand that the information disclosed as authorized in this agreement may be disclosed for the purposes of treatment.

I authorize payment of medical benefits to Julie L. Henry, MD, PC for any services rendered to me. I authorize the release of any medical information necessary to process this claim. I authorize the above provider to release any information to secure the payment of benefits. I have been given the opportunity to review the practice privacy statement and agree with the conditions. I authorize the use of this signature on all insurance submissions.

Signature:_____ **Date:** _____

Relationship of patient, if other than self: _____

ADULT PATIENT HISTORY FORM

Your Name: _____ Date: _____

Age: _____ Height: _____ Wt: _____

Occupation: _____

Employer: _____

Referred By: _____

Spouse's Name: _____

Are you ☐ Right handed ☐ Left handed?

Reason for Office visit: (Right / Left) _____

_____

Date of Injury: _____ (or) Length of symptoms: _____

Describe how your injury occurred: _____

_____

Where did your injury occur?

Do you believe your condition is Work Related? ☐ YES ☐ NO

Is your injury the result of an Auto Accident? ☐ YES ☐ NO

Are you currently working? ☐ YES ☐ NO

Have you had any of the following for this injury?

- ☐ Physical therapy
- ☐ Ultrasound
- ☐ Acupuncture
- ☐ Manipulations
- ☐ CT Scan
- ☐ MRI
- ☐ Surgery: _____
- ☐ Other: _____

Do you have any of the following symptoms:

Numbness	Tingling
Fevers / Chills	Wound Drainage
Infection	Weakness

Do you participate in any sports/fitness programs? _____

_____

Is there any other information you wish the Dr. to know? _____

_____

_____

_____

For office use

Physician Signature_____

Current Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any ALLERGIES to medications?

Describe reaction

☐ Penicillin ☐ Codeine ☐ Iodine/Contrast ☐ LATEX
☐ Metal Allergy ☐ Other: _____

Do you have any Medical Problems

☐ Anemia	☐ Diabetes	☐ Heart Disease	☐ Rheumatoid Arth
☐ Artificial Heart valve	☐ Drug Addiction	☐ High Blood Pressure	☐ Steroid Use
☐ Asthma	☐ Emphysema/COPD	☐ HIV/Hepatitis	☐ Stroke/CVA
☐ Bleeding disorder	☐ Epilepsy/Seizures	☐ Kidney Disorder	☐ Thyroid Disease
☐ Blood Clots/DVT	☐ Fibromyalgia	☐ Liver Disease	☐ Ulcers
☐ Cancer _____	☐ Head Injury	☐ Mitral Valve Prolapse	☐ Other _____
☐ Cholesterol	☐ Hearing Problems	☐ Multiple Sclerosis	_____
☐ Depression/Anxiety	☐ Heart Attack	☐ Reflux/GERD	_____

List previous surgeries

Date_____ Surgery_____
Date_____ Surgery_____
Date_____ Surgery_____
Date_____ Surgery_____
Date_____ Surgery_____

Family History

☐ Cancer	☐ DVT	☐ Heart Disease	☐ Stroke
☐ Bleeding Disorders	☐ Diabetes	☐ Rheumatoid Arthritis	☐ Other _____

Do you smoke? ☐ NO ☐ YES - # of packs per day_____ For how long_____

I had the opportunity to read and understand the privacy statement and patient-specialist partnership agreement for this office, I know I have the right to receive a copy.

Patient Signature_____

Physician Signature_____