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: _____

JULIE L. HENRY, MD, PC

PEDIATRIC NEW PATIENT HISTORY FORM

Name_____ Date: _____ Age: _____

Height: _____ Weight: _____ Date of Birth: _____ Sex: _____

Mother's Name: _____ Father's Name: _____

Pediatrician Name: _____ Office Phone: _____

Who referred you?: _____

WHAT ARE YOU BEING SEEN FOR TODAY? _____

_____

IS THIS ON THE RIGHT OR LEFT SIDE?_____ DATE OF ONSET: _____

HOW DID IT HAPPEN? _____

_____

HAVE YOU RECEIVED ANY TREATMENT? _____

_____

HAVE YOU HAD XRAYS? _____ WHEN: _____

WHERE: _____

LIST ANY MEDICAL PROBLEMS: _____

_____

_____

LIST ANY ALLERGIES TO MEDICATIONS: _____ REACTION _____

_____ REACTION _____

WHAT MEDICATIONS YOU ARE TAKING: _____

_____

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

Parent/Guardian Signature_____