Beaumont

Ostomy Clinic Troy
New Patient Paperwork
44199 Dequindre Rd, Area C POB, Suite 315
Troy, MI 48085
O: 844-259-7340 F: 248-964-1188

Patient Information

Today's Date:_____

Name: _____ Birth Date: _____/_____/_____

Social Security No: _____ E-mail Address:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: __(_____)_____ Cell Phone: _(_____)_____ Primary Care Physician:_____

Are you employed? Yes or No (circle one) If yes, Full Time or Part Time? (circle one)

Insurance: Please present Insurance Card(S) and Driver's License to the front staff at the time of your visit.

Medications and Allergies: These will both be reviewed at every visit while in the room. Please have your list handy.

Emergency Contact(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____Relationship:_____

Release of Patient Information

Do you wish to authorize the release of your medical information to another individual(s), such as spouse, significant other, parent, child, guardian, etc? ☐ Yes ☐ No

_____ _____
Name of individual to which information may be released **Relationship to Patient**

_____ _____
Name of individual to which information may be released **Relationship to Patient**

_____ _____
Name of individual to which information may be released **Relationship to Patient**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

Advance Directive

Do you have an Advance Directive? ☐ Yes ☐ No *If yes, please provide us with a copy for your electronic medical record.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the named insurance that we provided for today's visit. I understand that I am financially responsible for all charges for services rendered for my appointments whether or not paid by insurance. I authorize the use of my signature on all submissions. Ostomy Clinic Troy and their agents may use my health care information and may disclose such information to my insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related service.

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**