Professional Village Medical Center
John S. DeMare, DO
Joyce A. McDonald, DO
Steven R. Shepherd, DO
Frank A. DiPonio Jr, DO
13700 19 Mile Road, Sterling Heights, MI 48313
Phone (586) 247.6020 Fax (586) 737.2338

General Patient Information

Today's Date:				
Last Name:		First Name:		MI:
Date of Birth:	Sex: Male Female	Social Security Number:	Marital Status & Spouse Name (if applicable):	
Address:	Apt #:	City & State:	Zip Code:	
Primary Phone Number:	Home Cell Work	Secondary Phone Number:	Home Cell Work	
Employer:		Email Address:		
*****If Minor**, Responsible Parent's Name (Guarantor):	***Guarantor's Date of Birth:	***Guarantor's Social Security Number:		

Emergency Contact Information

Emergency Contact Name & Relation to Patient:	Emergency Contact Phone Number:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name:	Insurance Company Name:
Subscriber to Insurance:	Subscriber to Insurance:
Subscriber's Date of Birth & Social Security Number:	Subscriber's Date of Birth & Social Security Number:
Relationship of Patient to Subscriber: Self Spouse Child Other	Relationship of Patient to Subscriber: Self Spouse Child Other

How did you hear about us? (please cirlce your answer):

Internet Word of Mouth Hospital Another Doctor Insurance

Authorization and Agreements for Medical Treatment and Service

Consent for Treatment: I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered as advisable or necessary in the judgment of the physician.

Agreement to Pay for Services: Regarding treatment and medical services rendered to the patient, I agree to pay for all services. I understand and agree that upon receiving notification of balances that payment will be made promptly. I also understand that upon failure to pay for these services, a 1.5% fee may be added monthly to any account greater than sixty days. A commensurate fee may be added and sent to an agency for collection proceedings. I promise to pay for services rendered to, or on behalf, of the patient.

If my copay is not paid at time of service a $10 fee will be added to my account. If I fail to keep a scheduled appointment I will be charged the following amounts: $60 for non-routine visits and $100 for routine visits. If I am charged for these amounts I understand that these will also become my responsibility and may be sent to the collection agency for payment along with any unpaid balances.

Release of Information: I hereby authorize Professional Village Medical Center to release any information to my insurance company in the course of my exam or treatment if it becomes needed to process the insurance claim.

Insurance Benefits: I hereby authorize my insurance benefits to be paid directly to John S. DeMare DO PC (d/b/a Professional Village Medical Center). I am financially responsible for all non-covered and/or disallowed services.

Insurance Information: I understand that due to constant changes in insurance benefits, we are unable to maintain current coverage information on every patient's policy. If a physician who is not a participant with my specific insurance plan sees me, I may be responsible for any costs incurred. If a test is rejected due to patient's failure to notify the office of special insurance requirements, I may also be responsible for payment. I realize that it is my responsibility as the patient to be fully aware of my benefits such as hospital precertification, prior authorizations, second opinions, deductibles, co-pays, and laboratory coverage. I also realize that there may be insurance-billed charges that will not be reflected on my bill.

Medical Testing and Results: I understand that it is ultimately the patient's responsibility to contact the office for all testing, appointments, and the results of all tests performed on the patient.

I HAVE READ ALL OF THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS AND FULLY UNDERSTAND:

Patient's Full Name (Printed):	Date of Birth:
Signature:	Today's Date:
Relationship to Patient (if patient is a minor or if personal representative is signing):	

HIPAA LAW

Notice and Acknowledgement

I acknowledge that I am aware of HIPAA privacy practices. Upon request, a copy can be obtained in our office.

Patient's Full Name (Printed):	Date of Birth:
Signature:	Today's Date:
Relationship to Patient (if patient is a minor or if personal representative is signing):	

Is there a spouse, family member, or other person you would like us to be able to discuss your records / protected health information with? If yes, please fill in the below information.

I hereby designate and authorize the below named person (Personal Representative) to act on my behalf regarding the items listed below:

Receive Protected Health Information and any information that is or would be provided to me by the physicians at Professional Village Medical Center (John S. DeMare, DO PC; Joyce A. McDonald, DO PC; Steven R. Shepherd, DO PC; Frank A DiPonio Jr, DO PC)

Enforce any individual rights that I have regarding my Protected Health Information under HIPAA.

I understand that this designation will remain in effect unless I reveoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect.

Name of Personal Representative:
Relationship to patient:
Phone number of Personal Representative:

Signature:	Today's Date:

Professional Village Medical Center

John S. DeMare, DO
Joyce A. McDonald, DO
Steven R. Shepherd, DO
Frank A. DiPonio Jr, DO

Health History Information

Today's Date:		
Full Name:	Date of Birth:	Primary Language:
Race:	American Indian / Alaskan Native | Black / African-American | White | Asian Native Hawaiian / Other Pacific Islander | Multiple Races | Unknown | Refuse to Answer	
Ethnicity:	Hispanic (or Latino) | Non-Hispanic | Unknown | Refuse to Answer	

Pharmacy Information

Name of Local Pharmacy:	Approximate Location of Pharmacy & Phone Number:
Name of Mail Away Pharmacy (if applicable):	Address of Mail Away Pharmacy & Phone Number:

Allergies

Please list allergen along with what type of reaction occurs

Medication Allergies:	Food Allergies:
Contactant Allergies:	Environmental Allergies

Immunizations

Please answer all below to the best of your knowledge. If you have an existing record, please provide to us.

Name of Vaccine	Did you have?	If yes, when and where?
Pneumovax 23 (pneumonia vaccination)	Yes / No / Unsure	
Prevnar 13 (pneumonia vaccination)	Yes / No / Unsure	
Zostavax (shingles vaccination)	Yes / No / Unsure	
Td (Tetanus vaccination)	Yes / No / Unsure	
Tdap (Tetanus with pertussis vaccination)	Yes / No / Unsure	
Seasonal Influenza vaccination	Yes / No / Unsure	
Are you up to date with all other vaccinations?	Yes / No / Unsure	

Personal Medical History

Please answer all below based on your own, personal health history

Do you have, or have you had…

Cancer?	Yes / No	If yes, what kind?
Diabetes?	Yes / No	If yes, what kind?
Thyroid Disease?	Yes / No	If yes, what kind?
Stroke?	Yes / No	If yes, when?
Heart Disease?	Yes / No	
Heart Attack?	Yes / No	If yes, when?
Heart By-Pass/Stent?	Yes / No	If yes, when?
High Cholesterol?	Yes / No	
High Blood Pressure?	Yes / No	
Asthma?	Yes / No	
Anemia?	Yes / No	
COPD?	Yes / No	

Please list any other past medical conditions not mentioned above:

Family Medical History

Please answer all below based on your relatives' (parents, grandparents, siblings, children) health history

Are you adopted? Yes / No	Is your family medical history unknown? Yes / No

Does a relative have, or have they had… **indicate if maternal or paternal relative**

Cancer?	Yes / No	If yes, who & what kind?
High Cholesterol?	Yes / No	If yes, who?
Diabetes?	Yes / No	If yes, who & what kind?
Heart Disease?	Yes / No	If yes, who?
Heart Attack?	Yes / No	If yes, who?
Heart By-Pass/Stent?	Yes / No	If yes, who?
Stroke?	Yes / No	If yes, who?
Thyroid Disease?	Yes / No	If yes, who & what kind?
High Blood Pressure?	Yes / No	If yes, who?

Please list any other family medical history & conditions not mentioned above:

Social History

Do you exercise regularly?	Yes / No	If yes, how often and what form?	
Do you use any illicit drugs?	Yes / No	If yes, what kind and how often?	
Do you drink alcohol?	Yes / No	If yes, what kind, how often, and how much?	
Do you drink caffeine?	Yes / No	If yes, what is it and how many cups do you consume in a day?	
Do you use any tobacco? (this includes smokeless tobacco & "vaping")	Yes / No	If yes, what kind, how often, and how much?	
If you are a current smoker, how long have you been smoking?		If you are NOT a current smoker, are you regularly exposed to tobacco smoke?	
Are you a former tobacco user/smoker?	Yes / No	If yes, how many years did you smoke? _____ years	When did you quit?

Travel History

Have you travelled outside of the country in the last 6 months?	Yes / No	If yes, where?

Surgical History

Please list all previous surgical procedures & approximate dates:

Pregnancy/Birth History (females only)

Number of pregnancies:	Number of live births:

Diagnostic Studies / Health Maintenance

Please list all previous exam dates below (if able, please provide a copy to the office)

Last Complete Physical:	Last Colonoscopy:	Last Bone Density:
Last Stress Test:	Last Mammogram:	Last Pap Smear:
Last Dental Exam:	How often do you get dental examinations?	
Last Eye Exam:	How often do you get eye examinations?	

Medications / Supplements

Please list any current medications being taken, including all over-the-counter products and supplements. Please list what the dosage is and how often you take it. If the prescription is managed by another physician, please list who that physician is.

Medication/Supplement	Dosage	Frequency	Prescribing Physician