Thomas H. Beird, M.D.
800 Cooper Ave, Ste. 1
Saginaw, MI 48602
Ph: (989) 754-6916
Fax: (989) 754-4858

PATIENT INFORMATION

Patient Name:______________________Date of Birth:_________________Age:________
Social Security:_____________________Sex:________Marital Status:________________
Home Address:_____________________City:________State:______Zip:______________
Home Phone:_______________________Cell Phone:______________________________
Employed at:_______________________Occupation:______________________________
Work Address:______________________Work Phone:_____________________________
Emergency Contact Person:____
Relationship to Patient:______________Phone:___________________________________

SPOUSE, PARENT OR LEGAL GUARDIAN

Name(s):__________________________Date of Birth(s):__________________________
Social Security:_____________________2nd Parent:______________________________
Employed at:_______________________2nd Parent:______________________________
Work Phone:_______________________2nd Parent:______________________________

REASON FOR APPOINTMENT

Specific problem for visit:____
Have you consulted other doctors for this problem?_____________________________
Name of doctor or person who referred you to Dr. Beird:__________________________
Has Dr. Beird ever treated you before?_______ If yes, when?______________________
Family Doctor: ____________________________ Phone: ___________________________
Cardiologist: _____________________________ Phone: ___________________________

INSURANCE INFORMATION

Primary Insurance: ____________ Name on Card:_______________Date of Birth:______
Secondary Insurance:__________Name on Card:________________Date of Birth:______

WORKER'S COMPENSATION/AUTO INSURANCE

Written authorization must be obtained prior to your appointment or our office will not be billing under Worker's Compensation or Auto Insurance.

Date of work injury:____________Insurance Carrier:______________________________
Billing Address:________________Contact Person:_______________Phone:___________

Date of auto accident:__________Insurance Carrier:______________________________
Billing Address:________________Agent:_______________________Phone:___________
Claim #:______________________Policy Holder:___________________________________

HEALTH HISTORY

Height:____________________________Weight:________________________________

Please list allergies to medications, suture material, latex, tape or food:_______________

____

Please list medications, herbal preparations, vitamins or blood thinners and dosages you are taking, even if occasionally:____

____

Please list you daily consumption of the following: Coffee/Tea______________________

Alcohol________________Tobacco_______________Marijuana____________________

Please list any current illness or chronic health problems:__________________________

____

Please list any past hospitalizations: ____

____

Have you ever been diagnosed with:

______Tuberculosis	______Heart disease	______Arthritis
______Stomach Problems	______Diabetes	______Epilepsy
______Lung Disease	______High blood pressure	______Cancer
______Kidney Disease	______Mitral valve prolapse	______HIV

Please check if any of the following applies to you:

______Reaction to anesthesia	______Scarlet or rheumatic fever
______Bruise easily/bleed excessively	______Form large scars or keloids
______Frequent infections/boils	______Skin disease, hives, eczema, or rashes
______Shortness of breath	______Use of steroids, cortisone, or ACTH
______Back trouble	______Religion prohibits blood transfusions
______Emotional/psychological problems	

PLEASE READ

The policy of our office is to bill the necessary insurance company of possible. If we do not participate with your insurance, of you have a Master Medical policy, or your insurance cannot be billed, payment is necessary today by cash, check, Visa, or Master Card. If you cannot make payment for today's or any future non-covered office visit, please notify the receptionist prior to seeing Dr. Beird.

I authorize all medical information to be released to my insurance carrier and payment be made to Thomas H. Beird, M.D.

(If applicable) Consider this as my "ONE TIME AUTHORIZATION AGREEMENT" to permit payment of Medicare benefits to Thomas H. Beird, M.D.

I understand that Medicare will not pay for any procedure that is determined cosmetic and therefore payment is my responsibility.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the payment of any non-covered services. I have read all this information, completed the above questions, and certify this information to be true and correct to the best of my knowledge. I will notify Dr. Beird's office of any changes in my health, personal or insurance information.

I AGREE TO THE ABOVE INFORMATION BY SIGNING BELOW

____ _______________________

Signature of Patient or Legal Guardian of Patient Date

I acknowledge that I have read and understand the Notice of Privacy Practices for the office of Thomas H. Beird, M.D. This is for the purpose of the HIPPAA Privacy Act which was available upon request.

____ _______________________

Signature of Patient or Legal Guardian of Patient Date