

# Associated Dermatologists of West Bloomfield & Commerce

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In order to keep our records up to date, we ask that you complete this form if you have not been seen for more than 1 year in our office. If you have any questions or need help completing this form, please request assistance from the front desk staff. Thank you for your cooperation.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_@\_\_\_\_\_

**Have you had any changes to your insurance since your last visit:** Yes No  
If yes, please provide the following information: (please provide a copy of your insurance card)

Name of Insurance: \_\_\_\_\_

Subscriber's Name(unless self): \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number and or Name: \_\_\_\_\_

Subscriber's Relationship to Patient: (Circle One) Self Spouse Child/Dep

1. Have you had any changes to your medical/surgical history since your last visit? Yes No
2. Have you had any changes to your medications/allergies since your last visit? Yes No  
*Please update any medical history with the medical assistant when you begin your visit.*
3. Please provide the name & phone of your primary care OR referring Physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (or cross streets & City) \_\_\_\_\_

**Your signature is an acknowledgement that you are aware of the posted "Notice of Privacy Practices" of Associated Dermatologists of West Bloomfield & Commerce and that a copy of that policy is available upon request.**

\_\_\_\_\_  
(SIGNATURE OF PATIENT)

\_\_\_\_\_  
(DATE)