VITTORIO M. MORREALE M.D., PLC
50505 Schoenherr Rd, Suite 200, Shelby Township, MI 48315 586-803-1220 Phone 586-803-1277 fax

Yearly Patient Update

Name (first, middle initial, last): _____

Address: _____ City: _____ Zip: _____

Home#: (_____) _____-_____ Cell#: (_____) _____-_____ Work#: (_____) _____-_____

Marital Status: _____ Email address: _____

Emergency contact: _____ Relation: _____ Phone #: (____) _____ - _____

**Emergency Contact should have different number than the patient!! This person we should be able to contact if we can not get ahold of the patient.
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PCP/Internist (Family doctor) Name: _____ Phone#: (_____) - _____ - _____

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Do you have any Insurance changes since your last visit? Yes _____ No _____
If there has been changes and we are not notified, your insurance will be billed incorrectly and you might end up with a bill. So please make sure we have the correct billing information. If there are changes please update your information below……

If your insurance has changes to an HMO Insurance (A REFERRAL IS REQUIRED, IF ONE IS NOT OBTAINED YOUR APPOINTMENT WILL BE CANCELLED.)

Insurance Information:

Primary Health Insurance: _____
Subscriber: _____
Subscriber ID#: _____
Group # _____
Subscriber's date of birth: _____

Secondary Health Insurance: _____
Subscriber: _____
Subscriber ID#: _____
Group #_____
Subscriber's date of birth: _____

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Have you been injured in an Auto accident or Work Injury since your last visit? Yes _____ No _____
If there has been an injury we need to be notified so that we are billing correctly. We need the following information.
Insurance Company or Name of Employer _____
Adjustor or Case Manager Name and Phone #: _____
Claim # _____ Injury Date: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Phone#: _____ -_____ - _____

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The above information is accurate to the best of my knowledge. I hereby authorize the office of Dr. Morreale to release my medical information. I understand that there is a possibility that my insurance company may not cover all the charges related to my office visit(s) or other medical or surgical treatment(s). I understand that I am responsible for medical and/or surgical charges that my insurance does not cover.
I have read the above and agree:

Signature: _____ Date: _____