

******* IMPORTANT INFORMATION *******

WITHOUT THE APPROPRIATE INFORMATION YOUR APPOINTMENT MAY BE DELAYED.

PLEASE FOLLOW THESE GUIDELINES:

The information that is requested in these forms **is required**, so that if our office needs to order any Radiology Imaging or you need any Surgical Intervention your insurance requires us to have this information to get your tests or surgery **approved**.

Remember if we can't get your test or surgery approved it will delay your care.

1. Please mail, fax or drop off the **Patient Information Forms** that we sent to you to complete. These forms **MUST** be completed. If you send them back not fully completed they will be given back to you to complete at your appointment which will delay your visit.
2. Insurance cards & Drivers License **MUST** be present at the time of your visit.
3. Please bring **ALL** Radiology Imaging that you have pertaining to your visit. This can include MRI's, CT scan, X-rays, Bone Scans...etc. This must be in CD or Film form with the report.
4. **A REFERRAL IS REQUIRED for anyone with HMO Insurance**. This might come from your PCP (family doctor) or it might have to come from your insurance company depending on what your insurance requires. **The patient** is responsible to know what is needed. **Please contact your Insurance Company to verify.**

If we are billing a **Workers Comp** or a **Motor Vehicle Claim**. **Patient is responsible** to have their Adjustor or Case Worker send us an **OPEN CLAIM LETTER** this can be faxed, mailed or emailed to our office. If we **DO NOT** have this letter we **CAN NOT SEE YOU**. Please contact your Adjustor or Case worker to have them send this information to our office as soon as your appointment has been made. This letter contains all the billing information needed for our office so we know how we should be billing your visit.

Thank you,

Dr. Vittorio Morreale M.D. Office

50505 Schoenherr Rd. Suite 200, Shelby Twp., Michigan 48315

586-803-1220 phone 586-803-1277 fax

vmneurosurgery@sbcglobal.net

PATIENT INFORMATION

*****ALL QUESTIONS MUST BE ANSWERED. PLEASE DO NOT LEAVE ANYTHING BLANK*****

Name (first, middle initial, last): _____

Address: _____ City: _____ Zip: _____

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

Date of birth: ____/____/____ Sex: Male or Female

Social Sec #: ____ - ____ - ____ Language: _____ Race: _____ Ethnicity: _____

Marital Status: _____ Email address: _____

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

****Please DO NOT use home phone for EMERGENCY CONTACT!!**

PCP/Internist (Family doctor) Name: _____ Phone#: (____) ____ - ____

Ref. Physician Name: (if different) _____ Phone#: (____) ____ - ____

Do you have a HMO Insurance? YES or NO (IF YES, YOU MUST HAVE YOUR REFERRAL OR YOUR APPOINTMENT WILL BE CANCELLED.)

Insurance Information:

Primary Health Insurance: _____

Subscriber: _____

Group # _____

Subscriber ID#: _____

Subscriber's date of birth: _____

Secondary Health Insurance: _____

Subscriber: _____

Group # _____

Subscriber ID#: _____

Subscriber's date of birth: _____

AUTO AND WORK RELATED INJURIES

Is your injury the result of an AUTO accident? YES or NO (If so, please complete the following)

Is there an Attorney involved? YES or NO

Attorney Name: _____ Phone #: (____) ____ - ____

Do you have a coordination of benefits with your auto coverage for health insurance? YES or NO

Name of Insurance Company: _____

Adjustor name: _____ Adjustor's phone#: (____) ____ - ____

Claim #: (a claim # must be given to be a valid claim) _____ Injury date: _____

Is this a WORKERS COMPENSATION claim? YES or NO (If so, please complete the following)

Name of Employer: _____

Contact: _____ Phone #: (____) ____ - ____

Claim #: (a claim # must be given to be a valid claim) _____ Injury date: _____

Past Medical History (please list **ALL** medical history below, such as high blood pressure, cholesterol, cancer, diabetes, heart disease, HIV, mental illness, stroke):

Please list **ALL** medical conditions that run in your family and if they are **alive or deceased** (such as high blood pressure, cancer, diabetes, heart disease, stroke):

Father: _____

Mother: _____

Siblings: _____

Paternal Grandfather: _____ Grandmother: _____

Maternal Grandfather: _____ Grandmother: _____

(If applicable) Injuries related to any Auto or Workers Compensation Claims either past or present:

Past Injuries:

Surgeries, dates, and any complications:

Please list Medications and Vitamins that are taken on a daily basis:

Name of Medication (example) Motrin	Amount / Dosage's 1 tablet(s) / 20 mg	How often taken twice daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____

Pharmacy Phone#: _____ - _____ - _____

Please list all drug allergies:

Do you have Latex Allergies? _____ Do you have Adhesive tape Allergies? _____

Occupation (or if student, grade in school) _____

Highest level of education: _____

Tobacco Control

____ Current
____ **Former Smoker**
____ Nonsmoker

If current smoker: How often do you smoke?

____ every day
____ some days, but not every day

If current smoker: How many cigarettes a day do you smoke?

____ 5 or less
____ 6-10
____ 11-20
____ 21-30
____ 31 or more

If current smoker: How soon after you wake up do you smoke your first cigarette?

____ within 5 minutes
____ 6-30 minutes
____ 31-60 minutes
____ after 60 minutes

If current smoker: Are you interested in quitting?

____ Ready to quit
____ Thinking about quitting
____ Not ready to quit

If former smoker: How long has it been since you last smoked?

____ < 1 month ____ 3-6 months ____ 1-5 years ____ >10 years
____ 1-3 months ____ 6-12 months ____ 5-10 years

Alcohol Use

Did you have a drink containing alcohol in the past year? YES or NO

If yes: How often did you have a drink containing alcohol in the past year?

- _____ Never
- _____ Monthly or less
- _____ 2 to 4 times a month
- _____ 2 to 3 times a week
- _____ 4 or more times a week

If yes: How many drinks did you have on a typical day when you were drinking in the past year?

- _____ 1 or 2 drinks
- _____ 3 or 4 drinks
- _____ 5 or 6 drinks
- _____ 7 to 9 drinks
- _____ 10 or more drinks

If yes: How often did you have 6 or more drinks on one occasion in the past year?

- _____ Never
- _____ Less than Monthly
- _____ Monthly
- _____ Weekly
- _____ Daily or almost daily

Patient Questionnaire

Immunizations

FLU shot (Influenza) for Patients 18 years of age and older

Have you had your FLU shot this year? YES or NO (if NO was it a medical reason YES____ or NO____)

If "YES" approximately when did you receive it (date)? _____

Who administered your FLU shot? _____

(for example your PCP, CVS, Rite Aid)

Pneumonia shot for Patients **(65 years of age and older)**

Have you had your Pneumonia Shot? YES or NO (if NO was it a medical reason YES____ or NO____)

If "YES" approximately when did you receive it (date)? _____

Who administered your PNEUMONIA shot? _____

(for example your PCP, CVS, Rite Aid)

Elder Maltreatment Screening

For patients that are **(65 YEARS OF AGE OR OLDER)**

Is there any abuse in the home? YES or NO

Are you the one making the medical decisions? YES or NO

If NO, who is _____ Relationship _____

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: _____